

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10259

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY	
MONTGOMERY		BETHESDA		c. LENGTH OF STAY IN lb D.O.A		CHEVY CHASE		MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SUBURBAN		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		4803 WELLINGTON DR.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		SUBURBAN							
3. NAME OF DECEASED (Type or print)		First	Middle	lost	4. DATE OF DEATH	Month	Doy	Year	
FRANK RAPHAEL			ACOSTA		SEPT. 23			19 58	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years from birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/28/23	34 yrs.	Months 8	Days 25	Hours Min.	
10a. PROFESSION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Engineer		U.S. Govt.		Canal Zone		USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Frank R. Acosta				Alice V. Acosta					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes Navy WW 2		None		Alice V. Acosta-mother-same as 2d					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Insufficiency							
420.1 Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause last.		sudden							
(b)									
DUE TO									
Coronary Occlusion									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
Aspiration of gastric contents									
20a. EXTERNAL CAUSES OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		DATE SIGNED							
EXAMINER'S NAME (Type)		Frank J. Broschart							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county)	(State)			
Burial		9/26/58	Arlington National		Arlington, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE				
Robert A. Pumphrey Bethesda, Maryland				SEP 25 '58	Arthur S. Krause				

<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10300

CERTIFICATE OF DEATH

Reg. Dist. No.

10260

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 11 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,405 LORAIN AVENUE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) GEORGE		4. DATE OF DEATH SEPT. 22 1958	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10/31/21	
9. AGE (In years last birthday) 36		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Contractor		10b. KIND OF BUSINESS OR INDUSTRY (self-employed)	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. ADDRESS 10,405 Lorain Ave., Silver Spring, Md.	
13. FATHER'S NAME EDWARD E. ADAMSON		14. MOTHER'S MAIDEN NAME MINNIE KRUETER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW # 2 578-18-1916	
17. INFORMANT Mrs. Elizabeth R. Adamson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma right kidney DUE TO 180x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO with metastases (c)	
		INTERVAL BETWEEN ONSET AND DEATH 4 mos	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sept 21, 1958 (County) Baltimore (State) Md.	
21. I certify that I attended the deceased from Jan 1958 to Sept 1958 , that I last saw the deceased alive on Sept 21, 1958 , and that death occurred at 112 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 217 University Blvd E. St DATE SIGNED 9-22-58	
ACTUAL SIGNATURE Bernard A. Fitzgerald		PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/25/58	
22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MARYLAND (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Jaska		24a. REC'D BY REGISTRAR DATE SEP 24 1958	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE DEPARTMENT OF HEALTH - AGED WIVES

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10301

CERTIFICATE OF DEATH

Reg. Dist. No.

10261

1. PLACE OF DEATH o. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Maryland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herbert Nolan Adamson		First	Middle	Lost	4. DATE OF DEATH Month September	Month August	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1869	9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Robert L. Adamson		14. MOTHER'S MAIDEN NAME Helen Adamson		Address 5100 Muncaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO.		17. INFORMANT		Robert L. Adamson, Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) Advanced Sen. arterosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) OLNEY	(County) M.D. (State)
21. I certify that I attended the deceased from 7 Sept , 1958, to 10 Sept , 1958, that I last saw the deceased alive on 9 Sept , 1958, and that death occurred at 6:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE John B. Gartner						ADDRESS (Street, city or town, state) OLNEY, MD. DATE SIGNED 10 Sept 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-58		22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest G. Gartner		ADDRESS Gaithersburg, Md.		24a. REG'D BY REGISTRAR 10261		DATE 10 Sept 58	
						24b. REGISTRAR'S SIGNATURE Arnold S. Traut	

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VS A15 (4)
15M 10/57

COMMITTEE FOR THE UNITED STATES OF AMERICA
CERTIFICATE OF DATA

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G234 9/24/58 883

10262

10302

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Missouri		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 62 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weaubleau		d. STREET ADDRESS (no street address)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH September 16, 1958	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH October 25, 1888	9. AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Allen		14. MOTHER'S MAIDEN NAME Matilda Swicegood							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address Unascertainable					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). Probable primary neoplasm of lung or kidney (metastasis)?		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 13 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I attended the deceased from July 16, 1958 , to September 16, 1958 , that I last saw the deceased alive on September 16, 1958 , and that death occurred at 5:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE William R. Lewis M.D. DATE SIGNED 9/16/58									
PHYSICIAN'S NAME (Type) William R. Lewis, M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-21-58	22c. NAME OF CEMETERY OR CREMATORIUM Robbinison Cemetery	22d. LOCATION (City, town, or county) Weaubleau MO.	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home	ADDRESS 4812 GA Ave NW	24a. REC'D BY REGISTRAR DATE SEP 17 '58	24b. REGISTRAR'S SIGNATURE Carmer S. Thomas						

STATE OF TEXAS
DEPARTMENT OF CIVIL
SERIAL NUMBER

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10303

CERTIFICATE OF DEATH

10263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 41 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 5051 Bradley Boulevard		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ralph	Middle David	Last Anderson	4. DATE OF DEATH	Month September	Day 10, 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH October 11, 1917	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Days 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Febribication Inspector		10b. KIND OF BUSINESS OR INDUSTRY Fabricating		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Grover Anderson		14. MOTHER'S MAIDEN NAME Lizzie Connine						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 260-16-8045		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition DUE TO 286.0								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Nontropical Sprue DUE TO (c) Hypostatic Pneumonia, 24 hours 13 yrs.								
INTERVAL BETWEEN ONSET AND DEATH 2 yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 31, 1958 , to September 10, 1958 , that I last saw the deceased alive on September 10, 1958 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/10/58								
ACTUAL SIGNATURE D. G. O. Barnett M.D.								
PHYSICIAN'S NAME (Type) DR. G.O. BARNETT, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/11/58		22c. NAME OF CEMETERY OR CREMATORIUM Jeffersonville Cem.		22d. LOCATION (City, town, or county) Jeffersonville, Ga. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur J. Knudt		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10304

CERTIFICATE OF DEATH

10264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 Joseph Street		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 403 Joseph Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) THEODORE		First WILLIAM ARTHUR	Middle TIGER	4. DATE OF DEATH Sept. 16 1958	Month Sept.	Day 16	Year 1958			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15 1907	9. AGE (in years from birthday) 50 yrs	10. IF UNDER 1 YEAR 1 months	11. IF UNDER 24 HRS 21 days	12. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bulldozer		10b. KIND OF BUSINESS OR INDUSTRY Operator		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-2398		17. INFORMANT Alice V. Armiger-wife-same as 2d		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CEREBRAL EMBOLISM		INTERVAL BETWEEN ONSET AND DEATH 24 HOURS						
DUE TO, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		ATELECTASIS - LEFT CHEST		2 MONTHS						
DUE TO (c)		BRACHIOGENIC CARCINOMA		6 MONTHS						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from July 29, 1958 to Sept 16, 1958 , that I last saw the deceased alive on 14 Sept 1958 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) GUTHERSBURG, MD		DATE SIGNED 16 Sept 1958
ACTUAL SIGNATURE Gordon S. Rosenberger		M.D.								
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumprey Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Cirrus S. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10305

CERTIFICATE OF DEATH

Reg. Dist. No.

18265

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		c. LENGTH OF STAY IN 1b Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Rest Home		d. STREET ADDRESS 4010 Essex Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ANNA		First A	Middle M	Last ATCHLEY	4. DATE OF DEATH Sept. 17 1958	Month Sept.	Day 17	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/22/1872	9. AGE (In years lost birthday) 86	IF UNDER 1 YEAR IF UNDER 24 HRS Months 4		Years 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Charles A. Holloway		14. MOTHER'S MAIDEN NAME Lavina ?						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. P. Wilcox-daughter-same as 2D		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arterio Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 days 20 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 6A		(County) Rockville (State) Md.
21. I certify that I attended the deceased from Oct 17, 1958 , to 17 Sept 1958 , that I last saw the deceased alive on 17 Sept 1958 , and that death occurred at 6A , M, from the causes and on the date stated above. ACTUAL SIGNATURE William S. Murphy M.D.						ADDRESS (Street, city or town, state) 615 Montgomery Ave., Rockville, Md.		DATE SIGNED 17 Sept 1958
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/17/58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory		22d. LOCATION (City, town, or county) Suitland		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10266

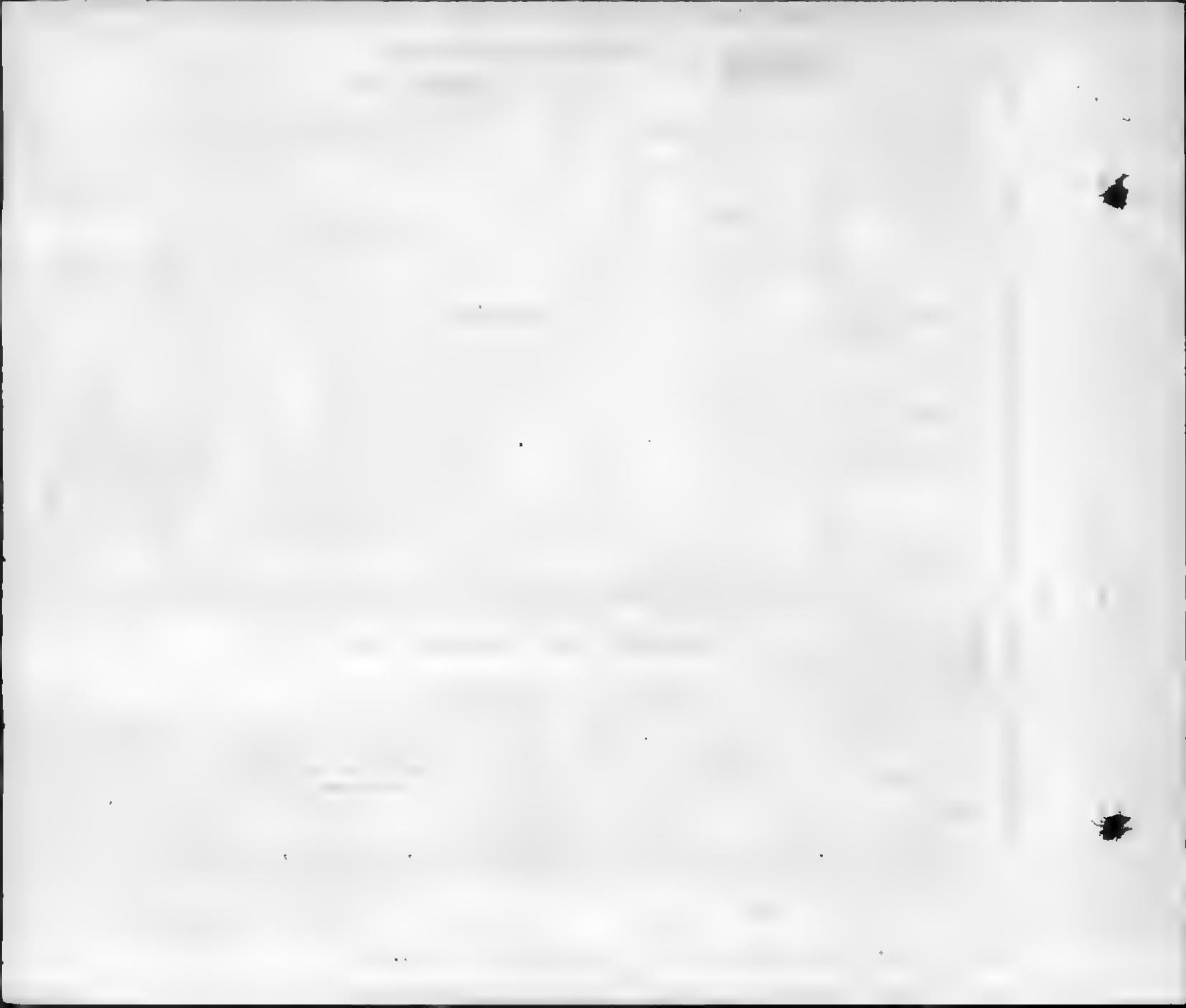
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4881 Battery Lane				d. STREET ADDRESS 4881 Battery Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CLARENCE	Middle CLIFFORD	Last ATWELL	4. DATE OF DEATH September 28,	Month 1958	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1873	9. AGE (In years less birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 26	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Manager		10b. KIND OF BUSINESS OR INDUSTRY Ohio Audit Bureau		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 275-01-0189		17. INFORMANT Mrs. Harriet Blackstone-same as 2d		Address Daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH Bounced years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20, 1956, to 9/28, 1958, that I last saw the deceased alive on 8/22, 1958, and that death occurred at 6:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Paul D. Cantor</i> M.D.						ADDRESS (Street, city or town, state) 4709 Montgomery Lane, Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 10/1/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Zanesville, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10267

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE							
<i>Montgomery</i> MARYLAND		Md.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY							
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>608 Dale Drive</i>		d. STREET ADDRESS <i>608 Dale Dale</i>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle						
<i>Valorous Gage Austin</i>		Last	4. DATE OF DEATH						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Day	13. Year
<i>M</i>		<i>W</i>		<i>April 1, 1902</i>	<i>56</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Private Detective.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Credit Investigator</i>		11. BIRTHPLACE (State or foreign country) <i>Washington</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Valorous G. Austin</i>		14. MOTHER'S MAIDEN NAME <i>Blanche I. Boss</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-34-8016</i>		17. INFORMANT <i>Mae C. Austin wife</i>		Address <i>608 Dale Dr. SS. Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO <i>Nephrosclerosis</i>		1 year					
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>advanced cerebral arteriosclerosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Prince George, Md.</i>		(County)	(State)
19									
21. I certify that I attended the deceased from <i>Aug 15</i> , 1957, to <i>Sept 5</i> , 1958, that I last saw the deceased alive on <i>Sept 4</i> , 1958, and that death occurred at <i>6:15 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>6234 Taivey W. Wash. D.C.</i>		DATE SIGNED <i>9/5/58</i>	
ACTUAL SIGNATURE <i>D.B. Washington</i>									
PHYSICIAN'S NAME (Type) <i>Daniel B. Washington</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF <i>9/8/58</i>		22c. NAME OF CEMETERY OR CREMATORIY <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince George, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. Washington 9, D.C.</i>		24a. REC'D BY REGISTRAR <i>SEP 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed with the funeral director.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10308

CERTIFICATE OF DEATH

10268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
3. NAME OF DECEASED (Type or print) Charles Joseph Ayers		4. DATE OF DEATH Month Sept. Day 26 Year 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX M le	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Ayers		14. MOTHER'S MAIDEN NAME Mary S. [unclear]	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Charles J. Ayers Jr.		Address 8015 Glenbrook Rd. Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Arteriosclerotic Heart Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 12 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) q-26		20f. (City or town) Suitland	
(County) 9-26		(State) Maryland	
21. I certify that I attended the deceased from 8 AM - 9:21, 1958 , to 12:45 PM , 1958 , that I last saw the deceased alive on 9-26, 1958 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip P. James		ADDRESS (Street, city or town, state) M.D. Washington Clinic, D.C.	
PHYSICIAN'S NAME (Type) Philip P. James		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/58	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 30 '58	
		24b. REGISTRAR'S SIGNATURE Charles S. Thrall	



17

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate would be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

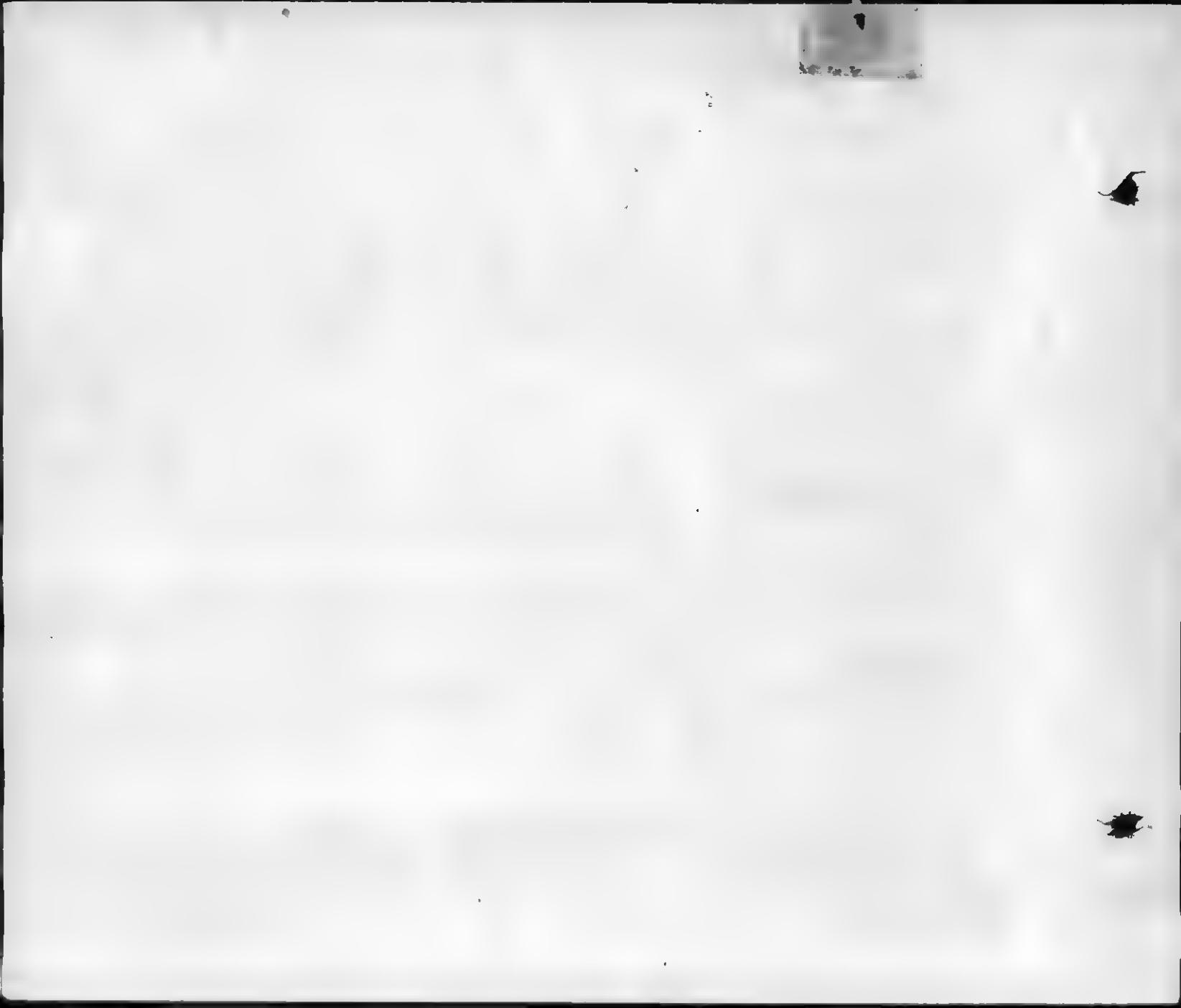
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10269

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived, if institution, residence before admission]		Reg. Dist. No.	
Montgomery		MARYLAND			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN MD		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Silver Spring		6 yrs		Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Colisville-Beltsville Rd		Colisville-Beltsville Rd		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Leonard		G.	Bailey	9-13	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (in years last birthday) 36 3/4 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
Male		col	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 29, 1922	11. IF UNDER 24 MONTHS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Clerk		U. S. Govt.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address	
Earl Bailey		Frances Rice		John I. Lancaster - 1st flr 2	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
		DUE TO Acute Cardiac Failure			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO Epileptic Seizures			
(b)					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		DATE SIGNED			
EXAMINER'S NAME (Type)		Frank J. Brosschart			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial		9-17-58		Arlington, VA	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE			
F. Scott L. Swanson		Sep 17 '58			
24b. REGISTRAR'S SIGNATURE		Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10310

CERTIFICATE OF DEATH

10270.

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
3. NAME OF DECEASED (Type or print) Curtis Warren		d. STREET ADDRESS 6312 93rd Ave.,	
5. SEX Male		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. WIDOWED <input type="checkbox"/>		9. DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Donald W. BARNARD		14. MOTHER'S MAIDEN NAME Alyce Ruby BABB	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 9-3-52 to 8-23-56		16. SOCIAL SECURITY NO. (Wife) Mrs. Nancy L. BARNARD (Same As #2)	
17. INFORMANT Hedgekins Deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Sept. 1958 , to 19 Sept. 1958 , that I last saw the deceased alive on 19 Sept. 1958 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Lige Thiale Jr.		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) AUGUST MIALE, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24a. REC'D BY REGISTRAR DATE SEP 23 '58	
ADDRESS 5801 Cleveland Ave., Riverdale, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10271

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

10311

1. PLACE OF DEATH

a. COUNTY

Montgomery
Silver Spring

c. LENGTH OF STAY IN lb

6 yrs

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1915 Locust Grove Rd.

3. NAME OF

(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

2-22-1900

9. AGE (In years
less birthday)

58 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machine

10b. KIND OF BUSINESS OR INDUSTRY

P. O. Dept

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Barr

14. MOTHER'S MAIDEN NAME

Julia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

17. INFORMANT

Ella Barr (wife)

Address: Item 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

420.1

Conditions, if any, which
gave rise to immediate cause
(a), sloing the underlying
cause lost.

DUE TO
(b)

DUE TO
(c)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Fresh dead
in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month, Day, Year
Hour a. m.
p. m.

19

20d. INJURY OCCURRED

While
of work Not while
of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

DATE SIGNED

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

9-6-58

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

24d. REC'D BY REGISTRAR

DATE

24e. REGISTRAR'S SIGNATURE

C. J. S. Funeral

DATE

10271

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10270 CERTIFICATE OF DEATH

10272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				b. COUNTY Montgomery			
c. LENGTH OF STAY IN lb 22 hours				c. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. + Hosp.				d. STREET ADDRESS 6800 Red Top Rd.			
3. NAME OF DECEASED (Type or print)		First Philip	Middle Martin	4. DATE OF DEATH SEPT. 15 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 19 82		9. AGE (in years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Preseman		10b. KIND OF BUSINESS OR INDUSTRY Preseman		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Martin BASHWINNER		14. MOTHER'S MAIDEN NAME Isabel Carpenter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Pt. hosp. Chart + wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MELANOCARCINOMA, PRIMARY - COLON Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) WITH METASTASIS TO LUNGS, BLADDER, LIVER (c) AND LEFT PYURETER AND PYONEPHROSIS							
INTERVAL BETWEEN ONSET AND DEATH MONTHS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Sept 15 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1958 to Sept 1958 , that I last saw the deceased alive on Sept 15 1958 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D. 7006 New Hampshire Ave. Tk. Pk. Md. 9/15/58							
DATE SIGNED Ernest A. Sarooms							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/58		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Rumphrey Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knau	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10273

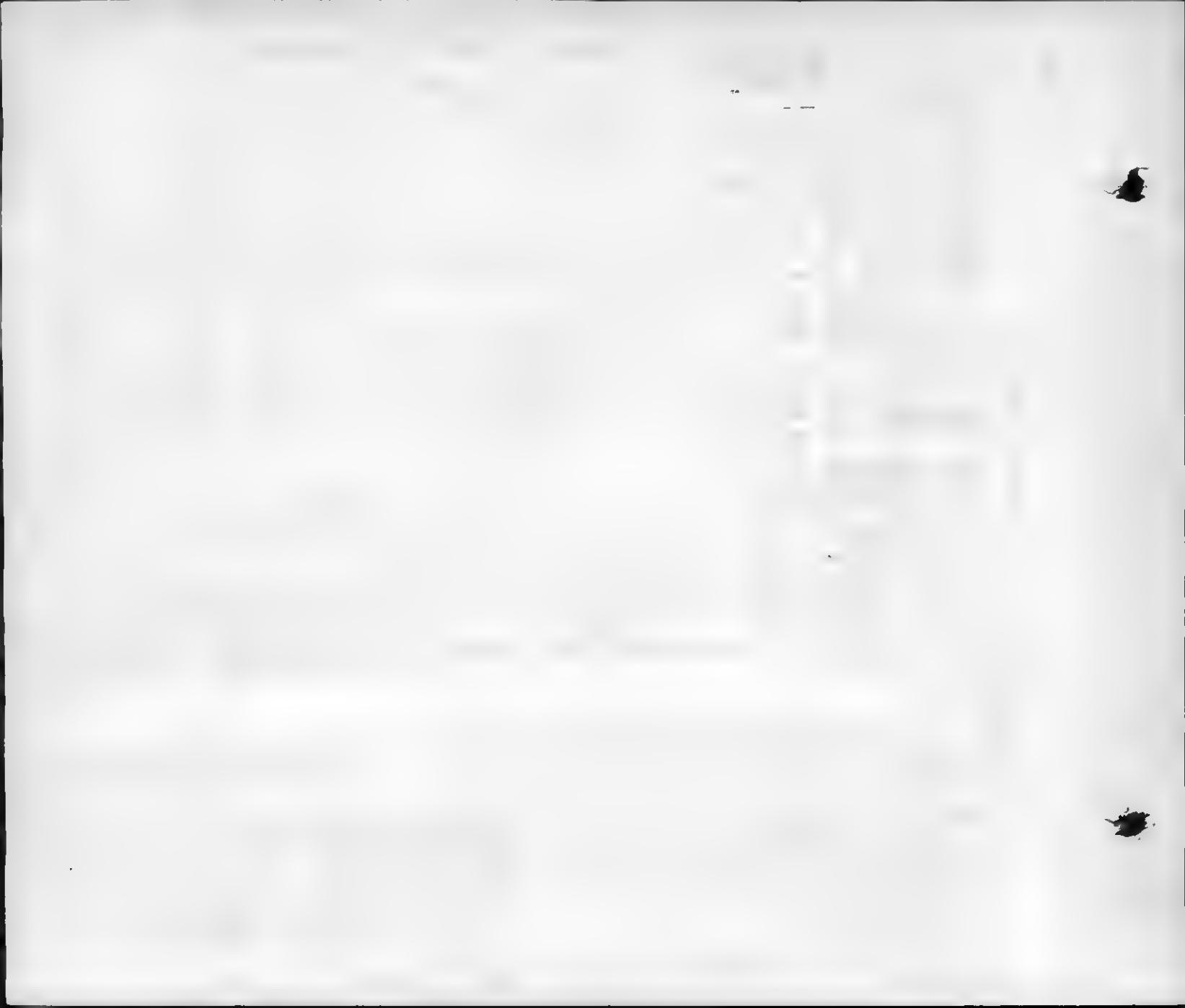
FOR STATE
HEALTH DEPT.

Reg. Dist. No

10312

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
Montgomery		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Silver Spring		45 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
813. 1/2 Miss. Blvd.		Silver Spring	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
813. 1/2 Miss. Blvd.			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Amy Lavinia Beall		Sept 8 1958	
5. SEX		5. COLOR OR RACE	
Female		White	
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. B. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/>		12-8-95	
8. DATE OF DEATH		9. AGE (In years last birthday)	
Month		62 yrs	
Day		10. CITIZEN OF WHAT COUNTRY?	
Year		Md.	
11. BIRTHPLACE (State or foreign country)		12. IF UNDER 1 YEAR Months Days Hours Min	
Md.		13. FATHER'S NAME	
Geo. W. Mulligan		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
(If yes, give war or dates of service)		17. INFORMANT	
housework		Wilma Lewis -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. INTERVAL BETWEEN DEATH AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion	
420.1		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		9-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Sept 10 1958	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
George Wash. Comt.		Prince George Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Deal Funeral Home 4812 Gt Ave NW		24a. REC'D BY REGISTRAR	
		DATE SEP 10 '58	
		24b. REGISTRAR'S SIGNATURE	
		John S. Thrus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10274

10313

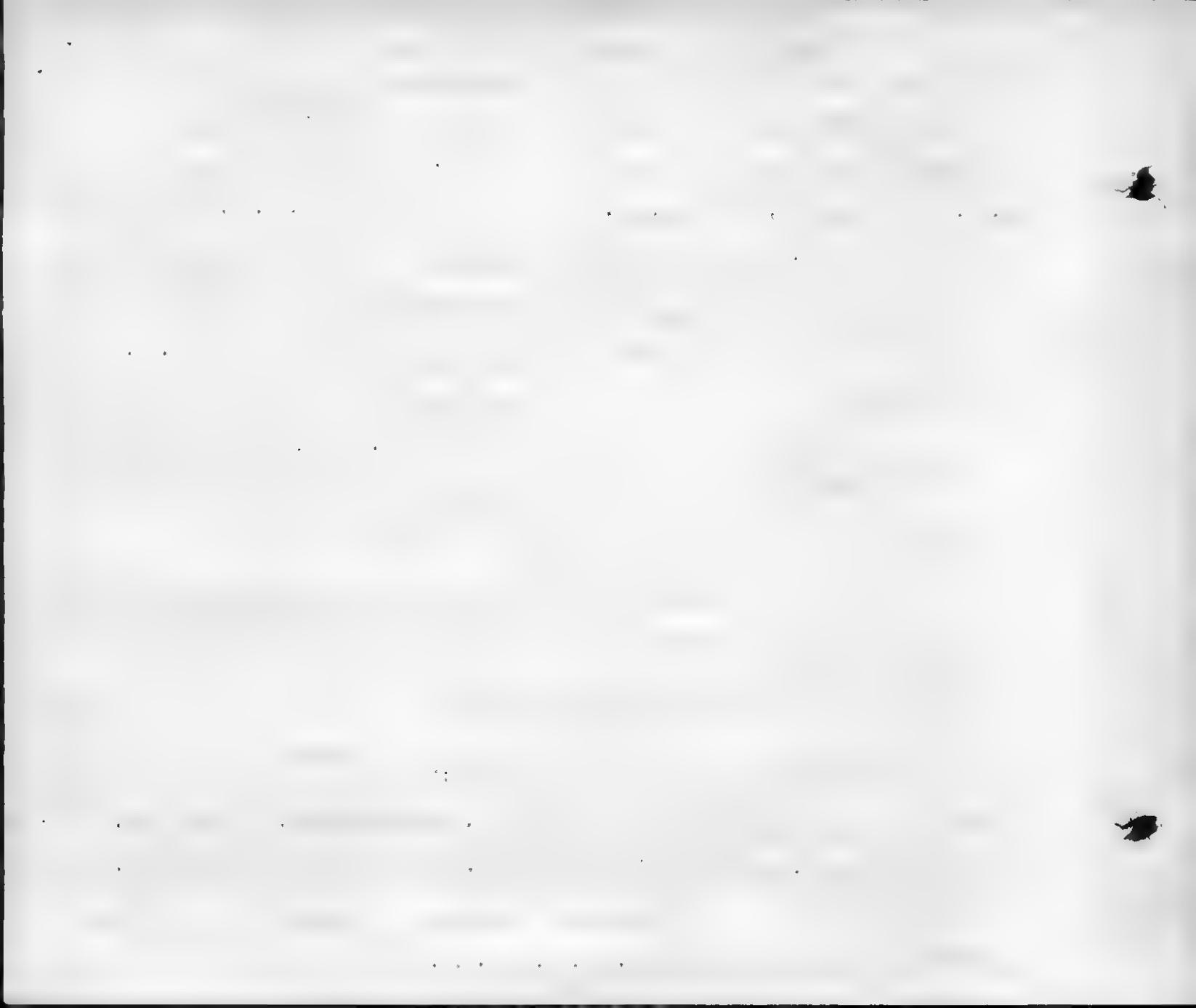
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 529 Eames Place, N. E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lillie Mae Roebuck		First	Middle	Last	4. DATE OF DEATH BELCHER	Month	Day	Year
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1922	9. AGE (In years lost birthday) 36 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours	12. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Elizah ROUNTREE				14. MOTHER'S MAIDEN NAME Lula HENDERSON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Joe N. BELCHER (Same as #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure		782.4 DUE TO				INTERVAL BETWEEN ONSET AND DEATH Immediate		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 15 September, 1958 , to 19 September 1958 , that I last saw the deceased alive on 19 September, 1958 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Douglas R. Koth</i>		M.D. U. S. Naval Hospital, Bethesda, Md. 9-20-58						
PHYSICIAN'S NAME (Type) Douglas R. KOTH		LT MC USN U. S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington		(State) Virginia
23. FUNERAL DIRECTOR'S SIGNATURE SPANGLER, Funeral Home, 524, 8th St., N. E., Wash. D. C.		ADDRESS U. S. Naval Hospital, Bethesda, Md.		24a. REC'D. BY REGISTRAR SEP 23 1958		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10275

10314

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 1 Seven Locks Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Grace	Middle Blockson	4. DATE OF DEATH	Month September	Day 4	Year 1958
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1901	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Geneviva Mason					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Jenny Wells (friend)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
446X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) <i>Arteriolonephrosclerosis</i>					unknown
		DUE TO (c) <i>Generalized arteriosclerosis</i>					extension
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Malaria</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 1, 1958</i> , to <i>Sept. 3, 1958</i> that I last saw the deceased alive on <i>Sept. 3, 1958</i> , and that death occurred at <i>1307</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. Bouditch Hunter Jr. M.D.</i>						ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL/CREMATION REMOVAL (Check one) <i>Burial</i>		22b. DATE THEREOF <i>Sept. 3, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Soldiers Home</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Karen L. Snodgrass-Rockwell</i>		ADDRESS <i>1000 Rockville Rd., Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Sept. 1, 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be handed to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.

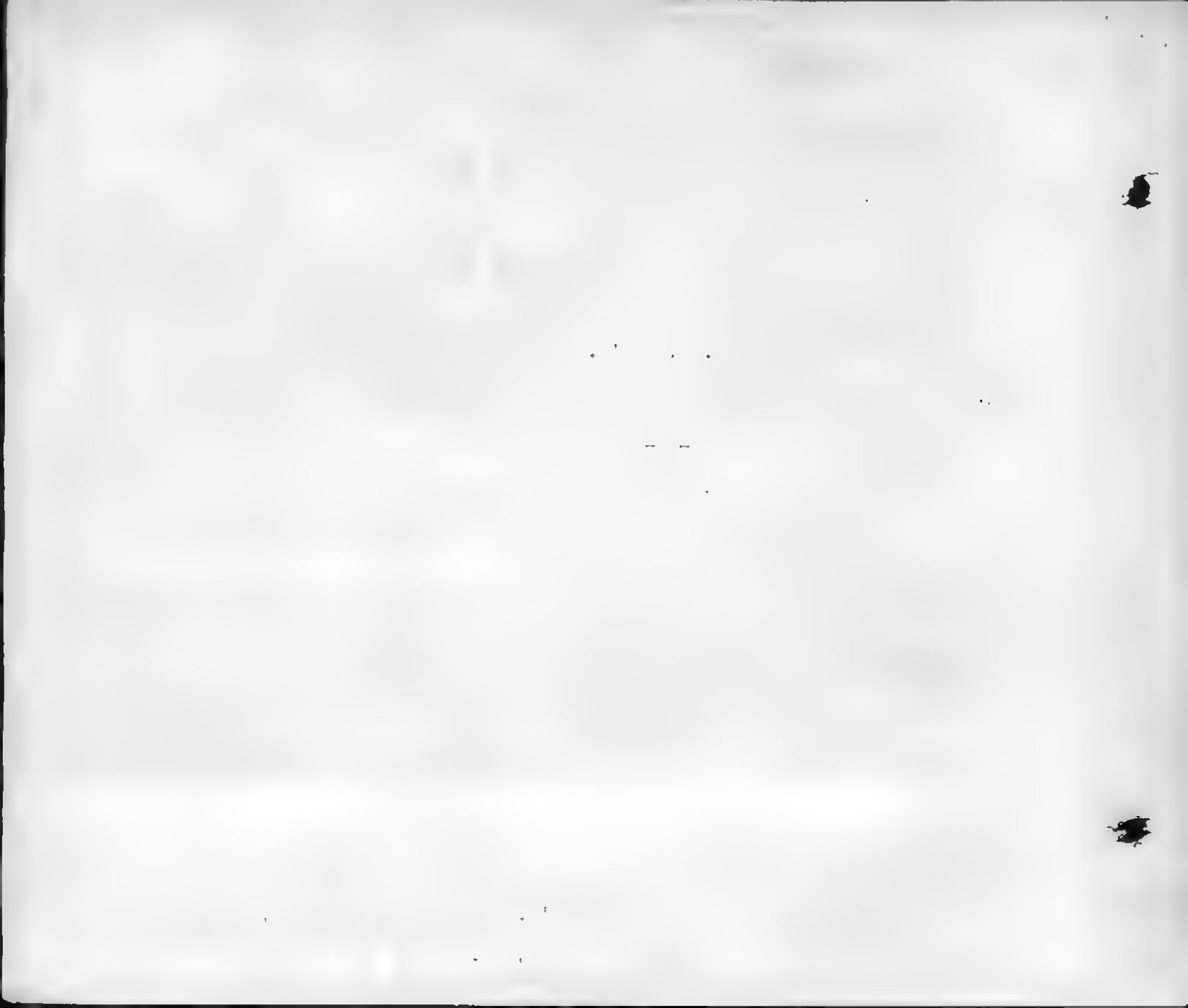
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10276

Reg. Dist. No.

10315

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery		b. STATE	
Silver Spring		b. COUNTY	
12621 Epping Rd		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
William Joseph Boland		d. STREET ADDRESS	
male white		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Middle		f. DATE OF DEATH	
Last		Month	Day
Sept 29		1958	
3. NAME OF DECEASED (Type or print)		4. DATE OF BIRTH	
William Joseph Boland		7-28-07	
5. SEX		8. DATE OF BIRTH	
Male		9. AGE (In years last birthday)	
White		51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
U. S. Marshall		U. S. Gov't.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Mass		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
WM Henry Boland		Mary Driscoll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
NO		579-22-3084	
17. INFORMANT		Address	
Gladys Boland (wife)		Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		sudden	
420.1		Coronary occlusion	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		9-29-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/2/58	
22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)	
22e. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Gitska,		24e. REC'D BY REGISTRAR DATE OCT 1 '58	
VS ATSM BM 2 57		24b. REGISTRAR'S SIGNATURE Arthur S. House	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10316

Item 9 filled in by funeral director.

CERTIFICATE OF DEATH

10277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY M.D.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON MD	c. LENGTH OF STAY IN 1b HOME KENSINGTON GARDEN NURSING	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDEN NURSING	e. STREET ADDRESS 2406 19TH ST NW	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM	First W	Middle E	Last BOOKWALTER
4. DATE OF DEATH SEPT 4 1958	Month SEPT	Day 4	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 24 1883
9. AGE (in years lost birthday) 74 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0
11. BIRTHPLACE (State or foreign country) KNOXVILLE TENN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIS BOOKWALTER		14. MOTHER'S MAIDEN NAME ELMIRA GUITNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MRS RUTH HUMMEL		Address 2406 19TH ST NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hypertension DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13 , 1958, to Sept. 4 , 1958, that I last saw the deceased alive on Sept. 4 , 1958, and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3924 BOSTON AVE KENSINGTON DATE SIGNED Sept. 4 1958			
ACTUAL SIGNATURE Katharine A. Chapman		M.D.	
PHYSICIAN'S NAME (Type) KATHARINE A. CHAPMAN		22d. LOCATION (City, town, or county) (State) Sutherland Maryland	
22e. BURIAL CREMATION, REMOVAL (Specify) CREMATION		22f. DATE THEREOF SEPT 6 1958	
22g. NAME OF CEMETERY OR CREMATORIUM Trajan Hills Cemetery		24d. REC'D BY REGISTRAR DATE SEP 8 '58	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Burch & Sons 3034 11st NW		24b. REGISTRAR'S SIGNATURE John G. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10273

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the ^{2nd} facsimile, writing the word "pending" in pencil on Pages 1, 2, and 3 to the funeral director. File ⁴ should be forwarded to the Chief Medical Examiner's Office along with farm PAGs. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME
5M 2/57

1 PLACE OF DEATH ■ COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN lb		d. STATE Md b. COUNTY Montgomery	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9404 Kingsley Ave		e. STREET ADDRESS 9404 Kingsley Ave		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) MARTHA		First	Middle	4. DATE OF DEATH BORZI	Month Sept Day 26 Year 1958
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 12/8/1883	9 AGE (in years last birthday) 74 yrs	IF UNDER 1 YEAR Months 9 Days 18 Hours 0 Min 0 IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Paul R Borzi		14. MOTHER'S MAIDEN NAME Santa Calderaro		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address 578-46-8824B Mary G Borzi Dtr Same # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart disease 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardio - renal disease 1 mo. (c) Carcinoma of left breast with metasyasis 7 mo.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 9/26/58	
EXAMINER'S NAME (Type) Frank J. Broschart	22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. DATE THEREOF 9/29/58	22d. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	22e. LOCATION (City, town, or county) Silver Spring, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Lumprey Bethesda, Maryland		ADDRESS Robert E. Lumprey Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 30 1958	24b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film

CERTIFICATE OF DEATH

Item 13, Film G-2-1930758.cac

Reg. Dist. No.

10279

1 PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days		b. STATE Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				b. COUNTY Prince Georges			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbia / Maryland							
d. STREET ADDRESS 5303 Clark Place		Washington 27, D.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jennie	Middle Elizabeth	Last Bowers	4. DATE OF DEATH	Month September	Day 17,	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 26, 1921	9. AGE (In years lost birthday) 37 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony Hanczarek		14. MOTHER'S MAIDEN NAME Tekla Knopik					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 35182815		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH			
2043 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) Intra cerebral hemorrhage					
		(c) Acute Myelocytic Leukemia		5 weeks			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I attended the deceased from September 11, 1958, to September 17, 1958, that I last saw the deceased alive on September 17, 1958, and that death occurred at 6:40 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 9/18/58	
ACTUAL SIGNATURE Arthur L. Teplitzky		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Arthur L. Teplitzky, M. D.							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 9-22-58		22b. DATE THEREOF 9-22-58		22c. NAME OF CEMETERY OR Crematory Arlington Nat'l.		22d. LOCATION (City, town, or county) Arlt. Myers, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE WW Chambless, chm.		ADDRESS 517-61ST ST SE Wash. DC		24a. REC'D BY REGISTRAR SEP 22 1958		24b. REGISTRAR'S SIGNATURE	

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1881-1882.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10280

10319

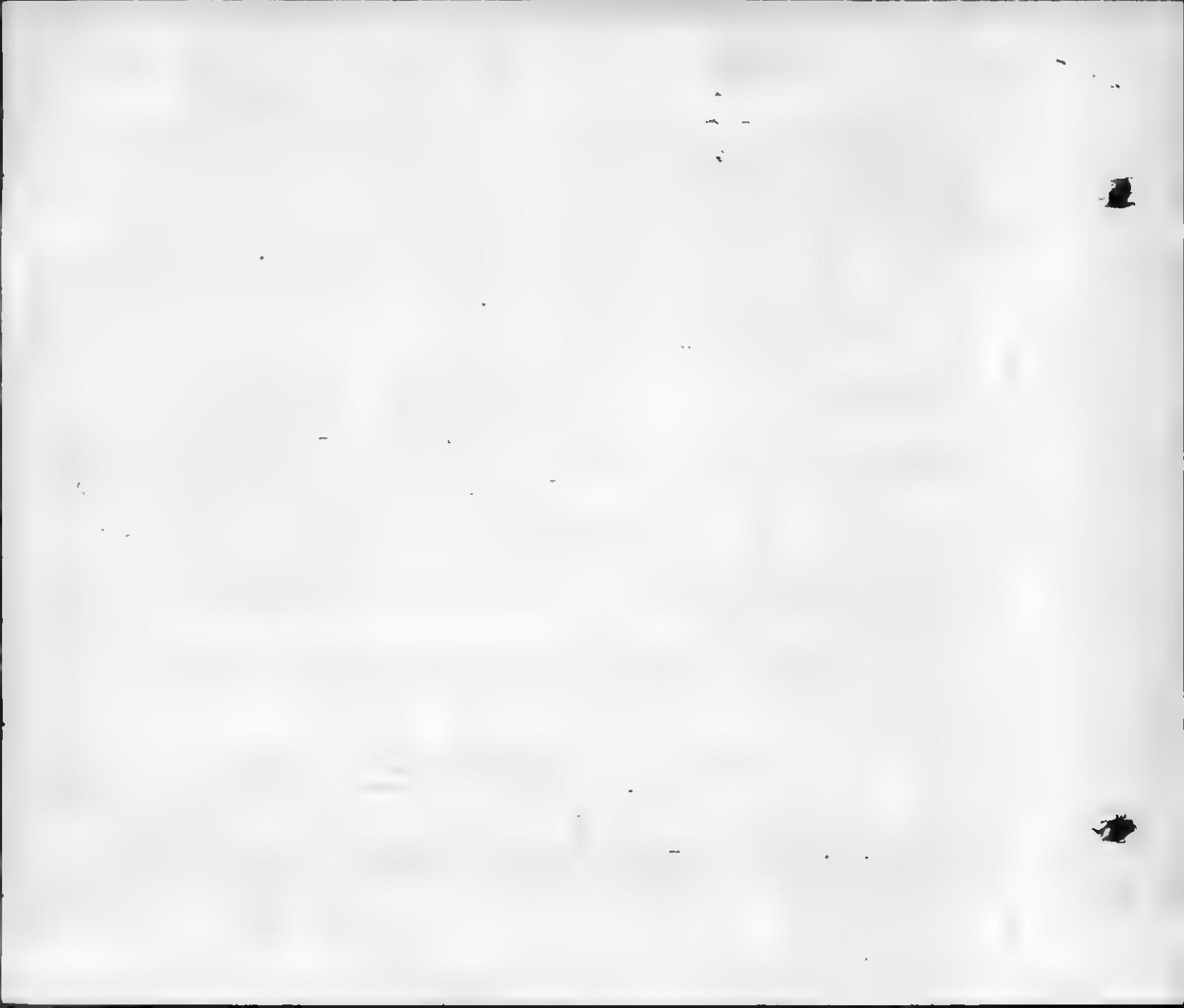
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield		d. STREET ADDRESS 15606 Parkston Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5606 Parkston Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First JOSEPHINE		Middle BROADBENT		4. DATE OF DEATH Sept. 3,	Month 19 58
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1886	9. AGE (in years last birthday) 71 yrs.	10. IF UNDER 1 YEAR 8	11. IF UNDER 24 HRS. 8	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Ryder				14. MOTHER'S MAIDEN NAME Margaret ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Leonard S. Broadbent-same as item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 7 MO.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				ARTERIOSCLEROSIS, GENERAL		4 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 9, 1956 to SEPT. 3, 1958 , that I last saw the deceased alive on SEPT. 2, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leo M. Curtis</i> M.D. ADDRESS (Street, city or town, state) Leo M. Curtis - 8218 Wisconsin Avenue, Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/58		22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven		22d. LOCATION (City, town, or county) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 5 '58		24b. REGISTRAR'S SIGNATURE <i>Curtis & Sons</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

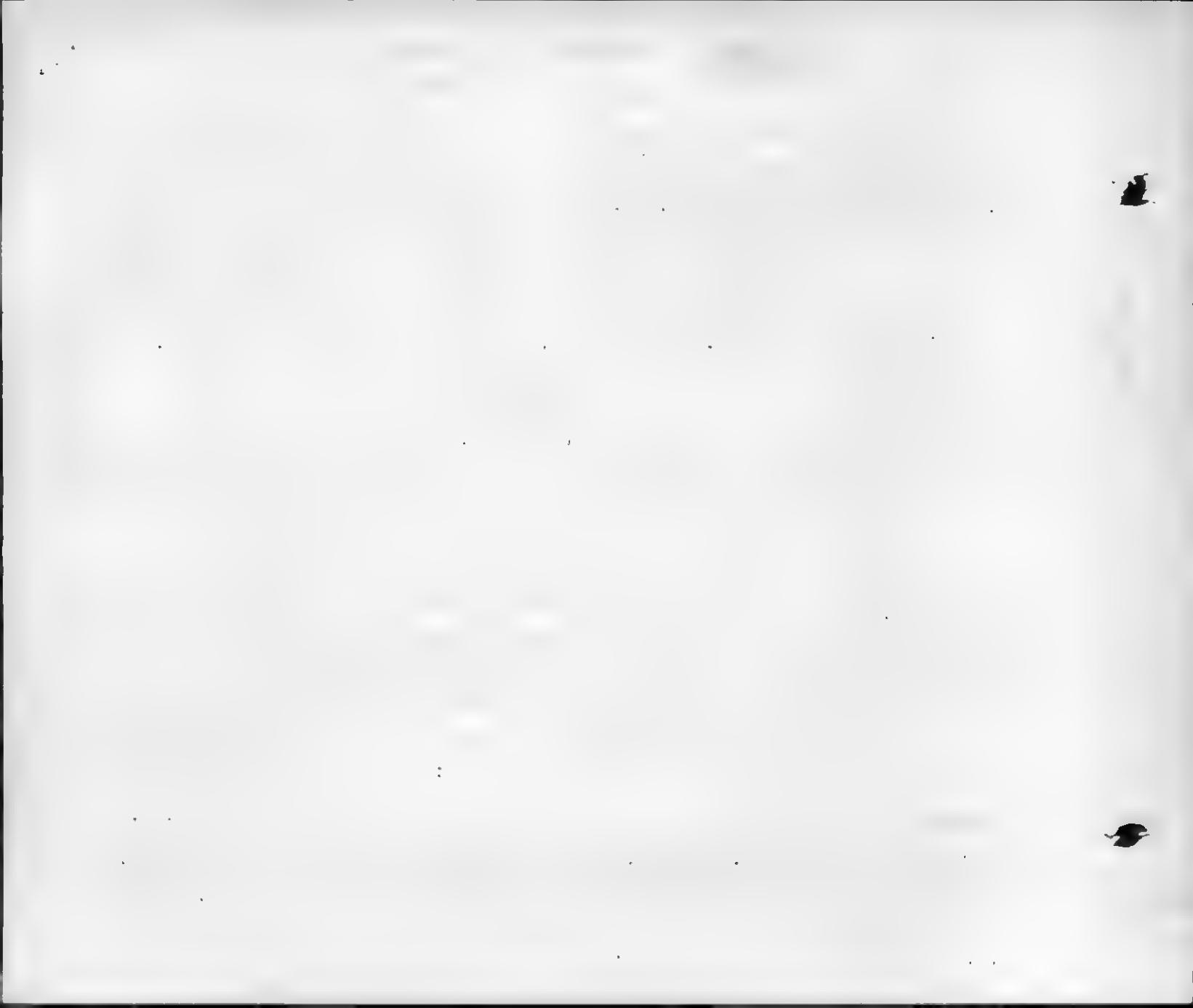
10320

CERTIFICATE OF DEATH

10281
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 43 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Waite	Last BUNKER
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 February 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	11. BIRTHPLACE (State or foreign country) Iowa	9. AGE (In years last birthday) 76 yrs
13. FATHER'S NAME Charles BUNKER	14. MOTHER'S MAIDEN NAME Isola BEASSWELE	12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO WW I & II	17. INFORMANT (Wife) Mrs. Eleanor G. BUNKER (Same As #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO Arteiosclerotic Heart Disease			
DUE TO Acute Pulmonary Edema			
C. DUE TO Many Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Myxedema			
Cirrhosis of Liver.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 August 1958 to 17 September 1958 , that I last saw the deceased alive on 17 September 1958 , and that death occurred at 1:35A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R.J. Pearson, Jr.</i>		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-17-58	
PHYSICIAN'S NAME (Type) R.J. Pearson, Jr. CAPT, MC, USN		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-22-58	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		22d. LOCATION (City, town, or county) Suitland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		ADDRESS 24a. REC'D BY REGISTRAR DATE SEP 22 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Krause	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

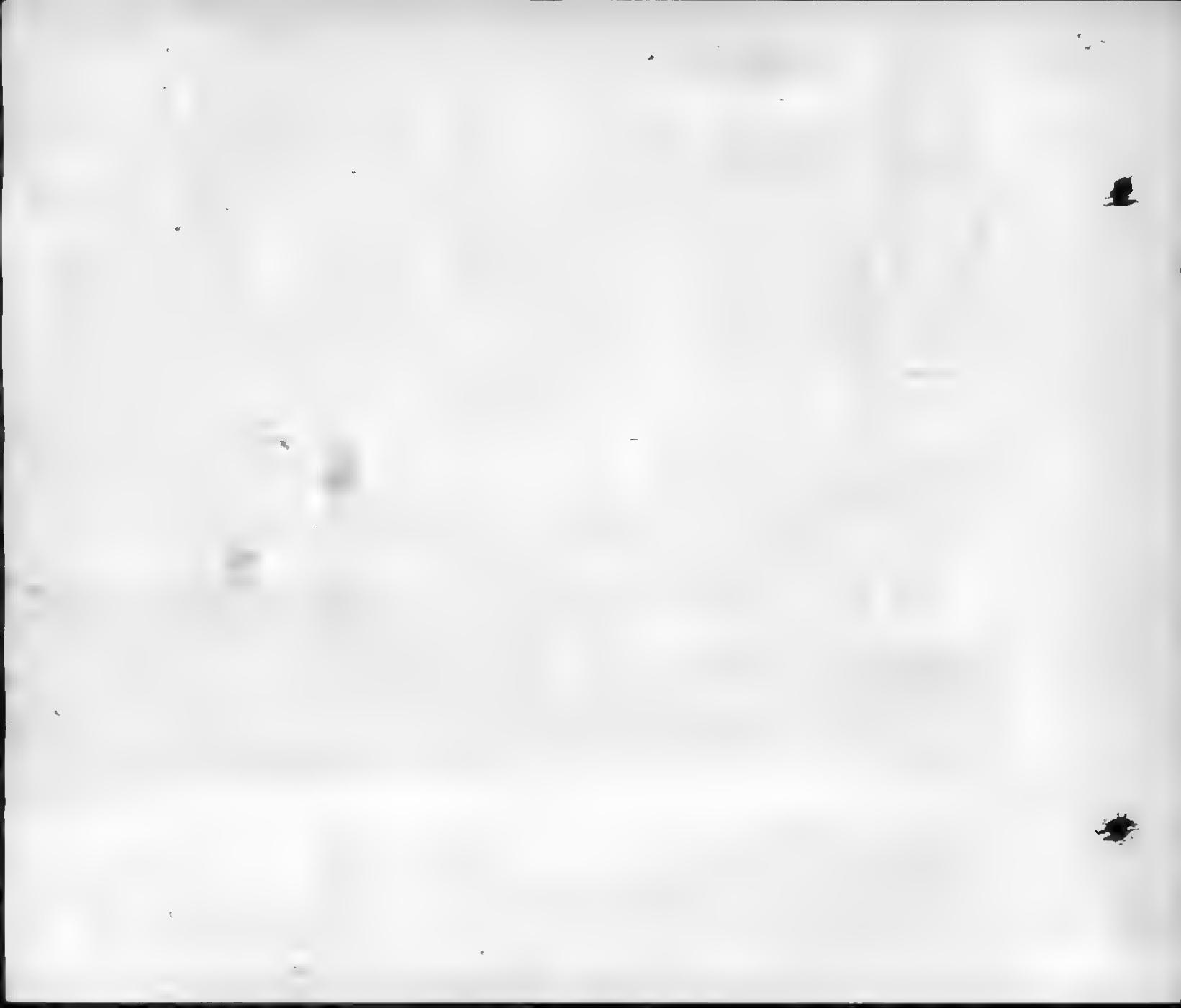
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10282

10321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlow Spring</i>		c. LENGTH OF STAY IN TB <i>1 wk</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3302 Weller Rd</i>		e. STREET ADDRESS <i>3302 Weller Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Edward Patrick Burke</i>		First	Middle
4. DATE OF DEATH <i>Sept 9 1958</i>		Month	Day
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>5-2-96</i>	9. AGE (In years less birthday) <i>62 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waiter first com.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>N.Y. state</i>	11. BIRTHPLACE (State or foreign country) <i>Mase</i>
13. FATHER'S NAME <i>Edward Patrick Burke</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>092/05-3171</i>	17. INFORMANT <i>Edward Burke (son) Item 2</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broadhurst</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>9-9-58</i>
EXAMINER'S NAME (Type) <i>FRANK J. BROADHURST</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MARYLAND</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL <i>9/11/58</i>	22b. DATE THEREOF <i>9/11/58</i>		24a. REC'D BY REGISTRAR DATE SEP 15 '58
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond L. Festa</i>	ADDRESS <i>SILVER SPRING, MD.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
VS. A15ME SM 2 57			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

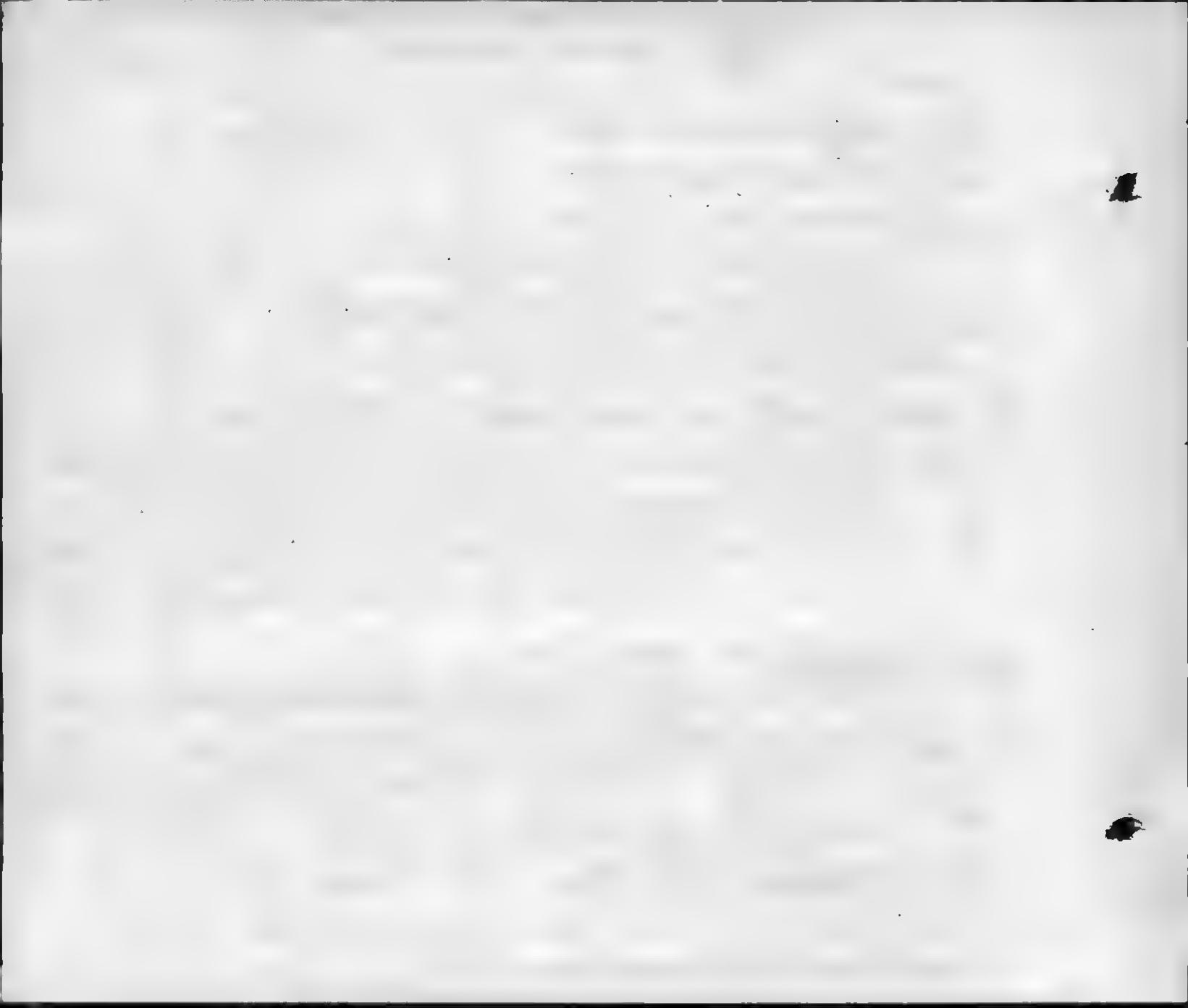
10322

CERTIFICATE OF DEATH

Reg. Dist. No.

10283

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C. MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 1b Aprox 3 wks +	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena's Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET		First	Middle
4. DATE OF DEATH Sept 21 - 1958		Last	Month
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 21 - 1870		9. AGE (In years less birthday) 88 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wm. Pender	
14. MOTHER'S MAIDEN NAME Mary Murphy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. J. Caesar - 1229-29th St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 72 hrs.	
CONGESTIVE HEART FAILURE		Arteriosclerotic Heart Disease 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 13, 1958 , to Sept. 21, 1958 , that I last saw the deceased alive on Sept. 16, 1958 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry J. Kicherer		ADDRESS (Street, city or town, state) 2205 Rockland St. Silver Spring, Md.	
DATE SIGNED 9-21-58			
PHYSICIAN'S NAME (Type) Harry J. Kicherer		22g. LOCATION (City, town, or county) WASHINGTON DC	
22h. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22i. DATE THEREOF SEPT. 25, 1958	
22j. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEMETERY		22k. REG'D BY REGISTRAR Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE He Vel Funeral Home 2214 N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
ADDRESS 2214 N.W.		DATE SEP 26 1958	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10284

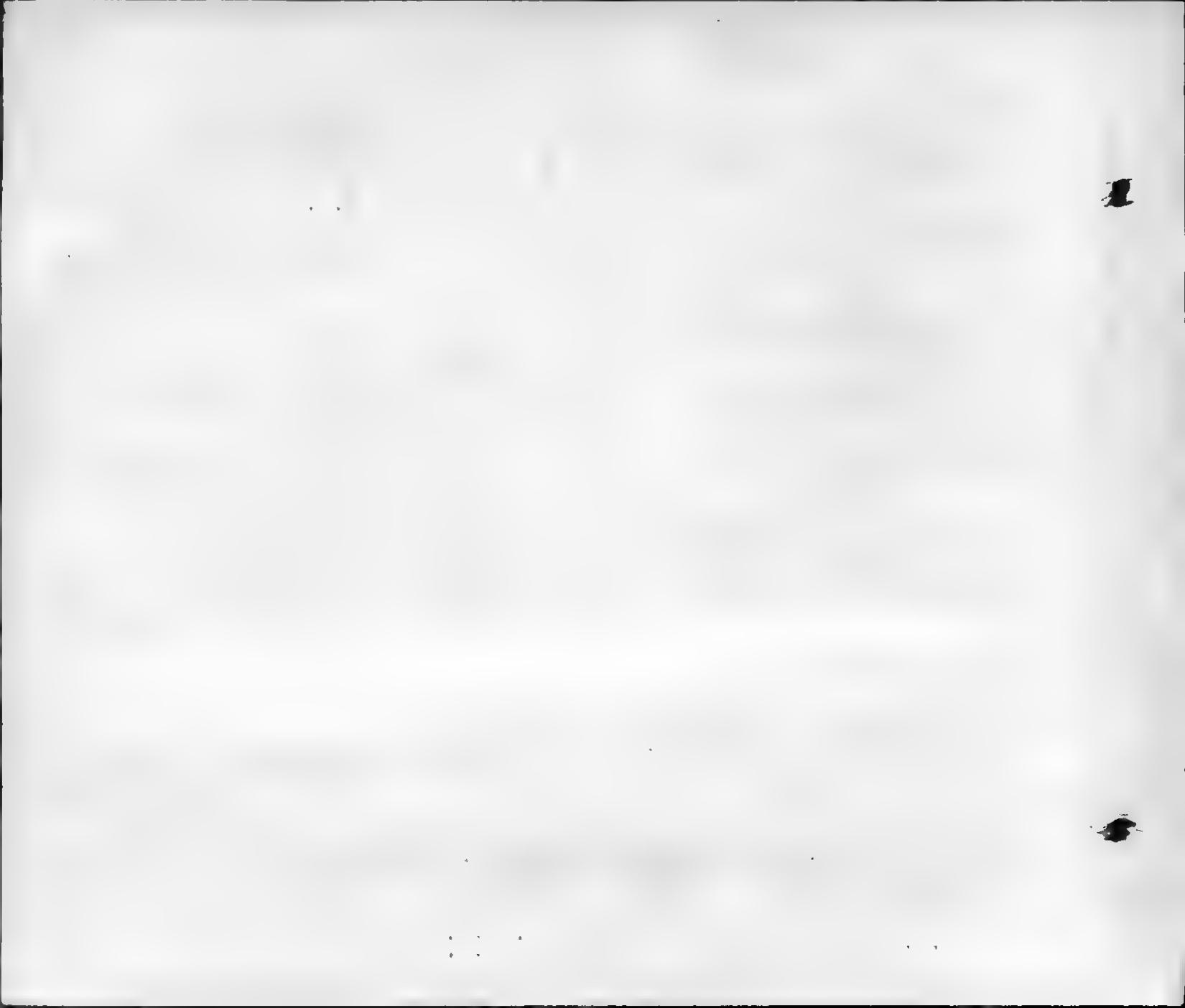
10323 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b lays		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON. D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		d. STREET ADDRESS 2001 16th St. N.W.	
3. NAME OF DECEASED (Type or print) ESTELLE		First B	Middle CAMPBELL
4. DATE OF DEATH SEPT. 21 1958		Month Sept.	Day 21
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4/3/78		9. AGE (In years lost birthday) 80 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Buffalo, New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Ball		14. MOTHER'S MAIDEN NAME Mary Cohn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Son (Geo. Campbell)
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, Posterior Septal & Posterior Left Ventricular 48 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Pulmonary Thromboses 48 DUE TO (c) Coronary Arteriosclerosis unknown			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy. Year Not while at work <input type="checkbox"/> of work <input type="checkbox"/>
20d. INJURY OCCURRED While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1938 , to Sept 21 , 1958, that I last saw the deceased alive on 21 Sept , 1958, and that death occurred at 9:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>John G. Ball</i>		M.D.	
PHYSICIAN'S NAME (Type) JOHN G. BALL 7936 Old Georgetown Rd. Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 9/22/58	22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery
22d. LOCATION (Cty. town, or county) Warren, Pa.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company			
ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR SEP 23 '58	24b. REGISTRAR'S SIGNATURE <i>C. Hines S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		10324		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery MARYLAND				o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d STREET ADDRESS 5908 Cedar Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Arthur Francis Carroll Jr.	Middle	Last	4. DATE OF DEATH September 21
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1911	9. AGE (In years lost birthday) 47 46 yrs.
			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Washington, D.C. U.S.A.	
13. FATHER'S NAME Arthur Francis Carroll		14. MOTHER'S MAIDEN NAME Annie Ryan		12. CITIZEN OF WHAT COUNTRY? Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary H. Carroll - Jane	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Immediate	
(b)		Ruptured Esophageal Varices		Immediate	
(c)		Hepatitis of Liver		Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-19, 1958, to 9-21, 1958, that I last saw the deceased alive on 9-20, 1958, and that death occurred at 6102A, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 5000 Penn Rd NW DATE SIGNED 9-21-58			
ACTUAL SIGNATURE W. Fleet Lickett					
PHYSICIAN'S NAME (Type) W. FLEET LICKETT					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-24-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Oliver	
22d. LOCATION (City, town, or county) (State) WASH., D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE James J. Ryan		ADDRESS 317 Penn Ave		24a. REC'D BY REGISTRAR 8C SEP 23 '58	
				24b. REGISTRAR'S SIGNATURE Cirrus S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10286					
10325 CERTIFICATE OF DEATH										Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Montgomery					MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					c. LENGTH OF STAY IN 1b 7 hrs. 5mins					b. COUNTY Montgomery					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County Gen. Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring										
3. NAME OF DECEASED (Type or print)		First Ella		Middle Mae		Last Carter		4. DATE OF DEATH		Month 9-	Day 28	Year 1958	# IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Female		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) 38 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Clifton Edward Thomas					14. MOTHER'S MAIDEN NAME Mary Simpson										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO		17. INFORMANT		Address									
				Eugene Carter		Sandy Spring, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350 X										Subdural Hematoma and					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										Sub-Arachnoid Hemorrhage -					
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
491X Broncho-pneumonia															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from 7/28 , 19 58 , to 7/28 , 19 58 , that I last saw the deceased alive on 7/28/58 , 19 58 , and that death occurred at 1:35 PM , from the causes and on the date stated above					ADDRESS (Street, city or town, state)					DATE SIGNED 8/30/58					
SIGNATURE A. D. Bonifant					M.D.										
PHYSICIAN'S NAME (Type) A. D. Bonifant					Sandy Spring					Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-2-58		22c. NAME OF CEMETERY OR CREMATORIAL Sandy Spring		22d. LOCATION (City, town, or county) Sandy Spring, Md.		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodder Rockville, Md.					ADDRESS J.					24a. REC'D. BY REGISTRAR 5/58		24b. REGISTRAR'S SIGNATURE Charles S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10287

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital	e. STREET ADDRESS Glen Hills	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Minnie	S First Middle L Last Minnie M Cavanaugh	4. DATE OF DEATH September 4 1958	Month Day Year September 4 1958
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH September 12, 1892
9 AGE (in years (last birthday) 2 yrs.		10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11 BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDRA Goroun		14. MOTHER'S MAIDEN NAME Hattie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-9319A 17. INFORMANT Mr. Bernard Cavanaugh—same as item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1744X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last:		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
(b) Cerebri DUE TO Cerebri (c) Thrombotic Ca from uterus.		1/6th. 9 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1958, to 2/4/1958, that I last saw the deceased alive on 2/4/1958, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE: Stephen N. Jones, M.D. ADDRESS (Street, city or town, state) Rockville, Maryland DATE SIGNED 2/8/58			
PHYSICIAN'S NAME (Type) Stephen N. Jones		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 9/8/58	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery	
22d. LOCATION (City, town, or county) (State)		22d. LOCATION (City, town, or county) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Morris	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10327

CERTIFICATE OF DEATH

10288
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 Days		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
						d. STREET ADDRESS 4323 Raleigh Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Elizabeth CHOPLOSKY		First Mary	Middle Elizabeth	Last CHOPLOSKY	4. DATE OF DEATH September 8 1958	Month September	Day 8	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 August 1958	9. AGE (In years last birthday) yrs 9	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Joseph CHOPLOSKY				14. MOTHER'S MAIDEN NAME Mary Elizabeth BRUBAKER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) John H. CHOPLOSKY (Same As #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 751X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Bacterial Meningitis, Acute		INTERVAL BETWEEN ONSET AND DEATH 1 day					
		DUE TO Meningoencephalitis, Subarachnoid		7 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 30 Aug 1958 to 8 Sept. 1958 , that I last saw the deceased alive on 8 Sept. 1958 , and that death occurred at 6:05A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE David Harris				M.D. U.S. Naval Hospital, Bethesda, Md. 9-8-58					
PHYSICIAN'S NAME (Type) David Harris, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58		22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 3072 "M" St., N.W. Washington, D.C.		ADDRESS W.W. Chambers, 3072 "M" St., N.W. Washington, D.C.		REC'D BY REGISTRAR SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knue			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10289

10328

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician until the funeral director,
TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, he should be filed with
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery</i>		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>5 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suebsb ame</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
f. STREET ADDRESS <i>725 Beall Ave.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Park Leo Christy</i>		First	Middle
4. DATE OF DEATH <i>Sept 9 1958</i>		Last	Month
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>9/18/58</i>		9. AGE (In years from birthday) yrs. <i>1</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Bethesda, Md.</i>	
10c. BIRTHPLACE (State or foreign country) <i>Bethesda, Md.</i>		11. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13. FATHER'S NAME <i>Leo E. Christy</i>		14. MOTHER'S MOTHER'S NAME <i>Barbara McFadden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>1</i>	
17. INFORMANT <i>Chart of mother</i>		Address <i>730 W. Montgomery Ave., Rockville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>massive Atelectasis, obstructive</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Anapleuroid hemorrhage, vertex</i> DUE TO (c) <i>Birth trauma</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congenital heart lesion - Patent foramen ovale & ductus arteriosus</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>11:55 PM</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>615 W. Montgomery Ave., Rockville, Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug. 8, 1958</i> to <i>Sept 9, 1958</i> , that I last saw the deceased alive on <i>Aug. 9, 1958</i> , and that death occurred at <i>11:55 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>615 W. Montgomery Ave., Rockville, Md.</i>			
ACTUAL SIGNATURE <i>Stephen C. Cromwell</i>		DATE SIGNED <i>Sept 9, 1958</i>	
PHYSICIAN'S NAME (Type) <i>Stephen C. Cromwell</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>9/12/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Rockville, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10329

CERTIFICATE OF DEATH

10290

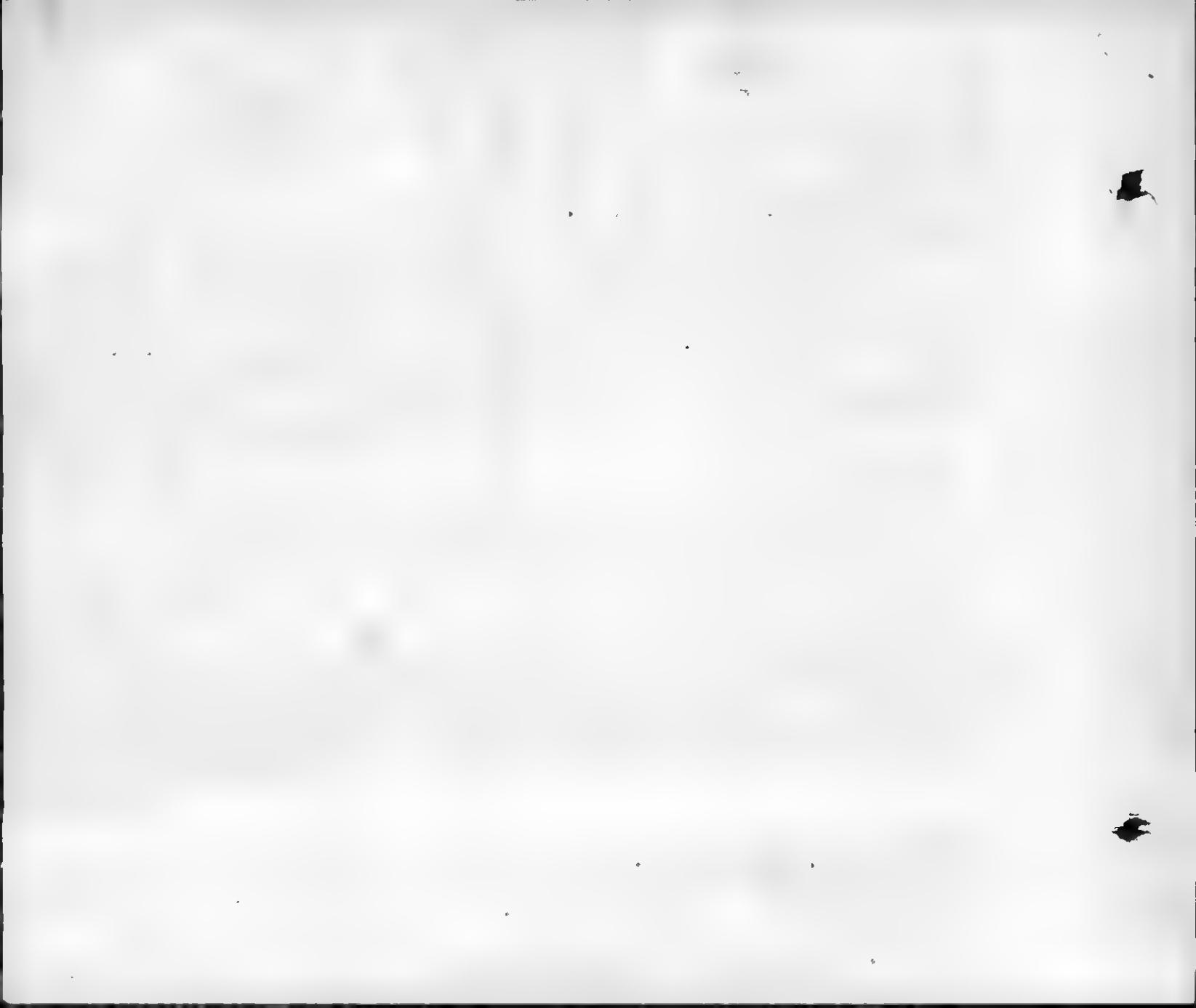
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Virginia		b. COUNTY Dickenson		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stratton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS No Street Address		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Polly	Middle Mae	Last Church	4. DATE OF DEATH September 12, 1958	Month September	Day 12	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 15, 1925	9. AGE (In years last birthday) 33 yrs	IF UNDER 1 YEAR Months 33	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Edward Newberry			14. MOTHER'S MAIDEN NAME Sarah Owens					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <input type="checkbox"/> (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pericardial hemorrhage, post</i> <i>atrial catheterization</i> <i>(PERICARDIAL HEMORRHAGE, POST LEFT</i> DUE TO <i>ATRIAL CATHETERIZATION)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic rheumatic valvular</i> <i>(CHRONIC RHEUMATIC VALVULAR)</i> DUE TO (c) <i>7 years</i> INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <i>Chronic rheumatic valvular (CHRONIC RHEUMATIC VALVULAR)</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from September 3, 1958, to September 12, 1958, that I last saw the deceased alive on September 12, 1958, and that death occurred at 6:53 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Leon I. Goldberg</i> M.D. The Clinical Center PHYSICIAN'S NAME (Type) LEON I. Goldberg, M.D. The National Institutes of Health Bethesda 14, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/58		22c. NAME OF CEMETERY OR CREMATORIAL Newberry Gem.		22d. LOCATION (City, town, or county) (State) Tarpon, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR not SEP 18 '58		
						24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10291

10330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>New Jersey</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 16 <i>2 mo 8 da</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Rest Home</i>		e. STREET ADDRESS <i>3418 Snowden Lane</i>	
3. NAME OF DECEASED (Type or print) <i>Charlotte Ireland</i>		4. DATE OF DEATH <i>Clinton</i>	Month Day Year <i>Sept. 21 1958</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 6 1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>Ireland</i>	
13. FATHER'S NAME <i>Charles Clinton</i>		14. MOTHER'S MAIDEN NAME <i>Frances Ann</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Mrs. John Dickinson 1521 Charles St.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>446X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>471</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Bronchopneumonia</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 30</i> , 19 <i>58</i> , to <i>Sept 21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 21</i> , 19 <i>58</i> , and that death occurred at <i>640 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>George Sharpe</i> M.D. ADDRESS (Street, city or town, state) <i>10511 Summit Ave</i> DATE SIGNED <i>1958</i>			
PHYSICIAN'S NAME (Type) <i>George Sharpe</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	
22b. DATE THEREOF <i>9/23/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	
22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey 9057 Maryland Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 23 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles J. Tracy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

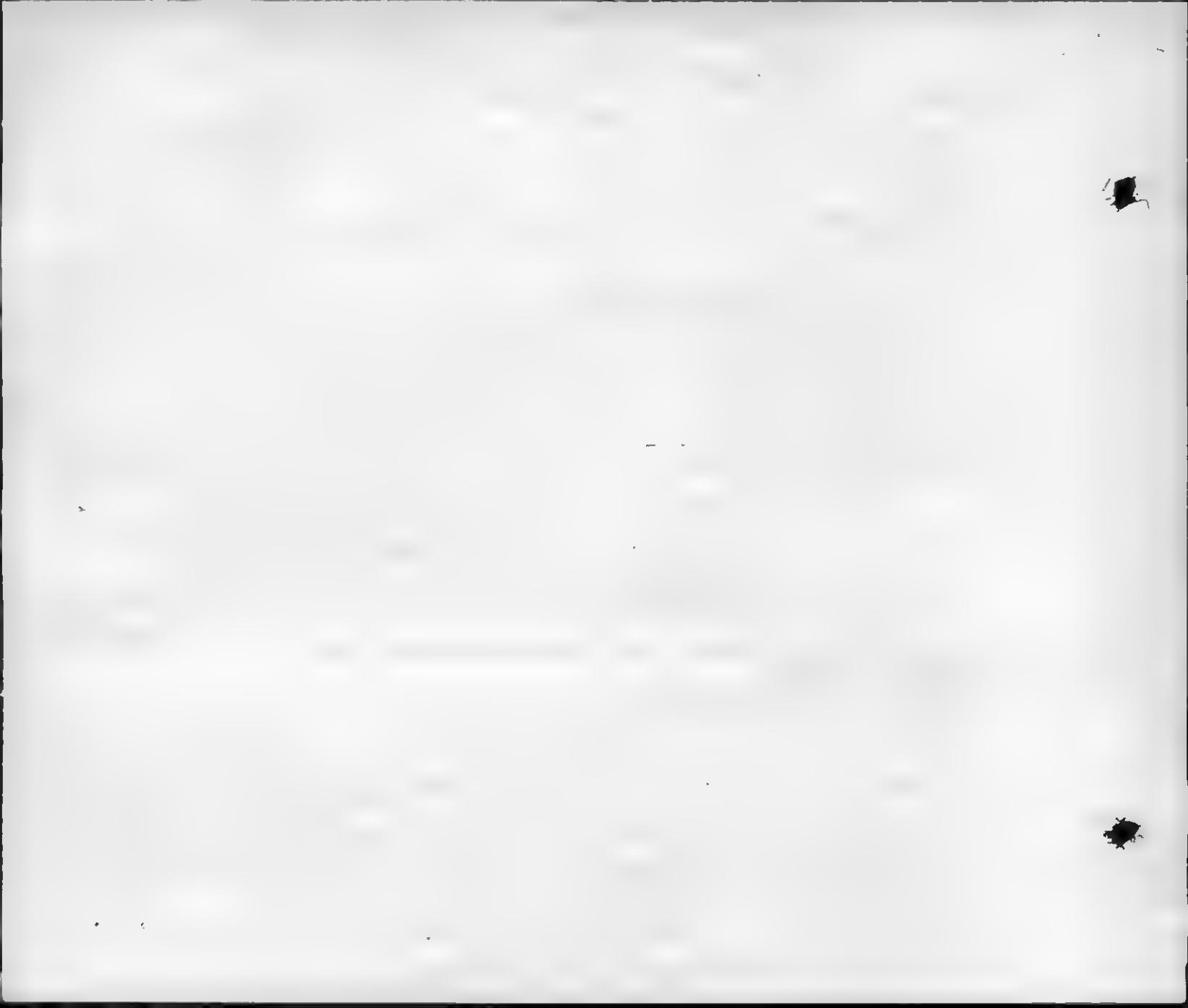
10292

10271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)			
Montgomery MARYLAND		a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Takoma Park 5 days.		Silver Spring MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS			
Washington San + Hospital		19604 Evergreen St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
	Walter	Milton	Collins		
4. DATE OF DEATH	Month	Day	Year		
	9	2	1958		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS
Male	white		9-27-85	72 yrs.	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Engineer + building Sup't.				D.C.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Collins - Mr. Albert G.		Mary Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		Address	
None		719-18-7479		Patient as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Primary Carcinoma left lung with			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		metastasis to liver. Pericardial effusion,			
(b) DUE TO		massive Pulmonary edema			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 13, 1958, to Sept 2, 1958, that I last saw the deceased alive on Sept 2, 1958, and that death occurred at 2:05 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE: Philip E. Jones M.D. ADDRESS (Street, city or town, state) 918 Ellsworth Drive 9-2-58 PHYSICIAN'S NAME (Type) Philip E. Jones DATE SIGNED 9-2-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
9/5/58				Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) (State)				22d. LOCATION (City, town, or county) (State)	
				Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Warren E. Quinquey 8434 Ga Ave		Silver Spring, MD		DATE SEP 5 1958	
				24b. REGISTRAR'S SIGNATURE	
				Orton S. Knott	

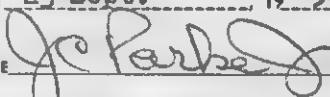
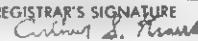


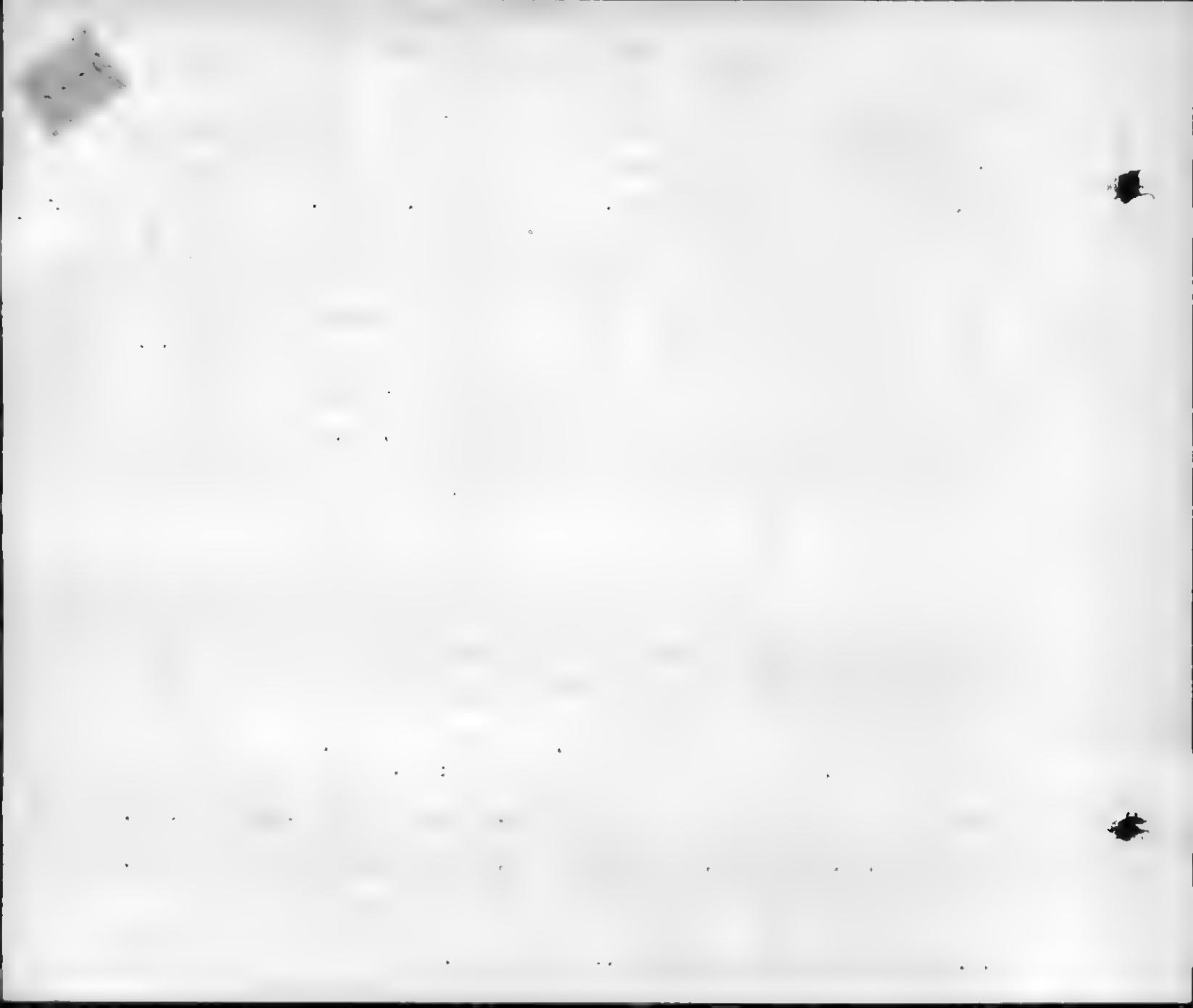
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10293

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 234 S. Blake Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle Rodreick	Last CONGER	4. DATE OF DEATH September 23 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 June 1944	9. AGE (In years last birthday) 14 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Henry Jackson CONGER		14. MOTHER'S MAIDEN NAME Lois Jane RODREICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <input type="checkbox"/> (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT (Father) Henry J. Conger, (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Hodgkin's Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs+			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Norfolk (County) Virginia (State)	
21. I certify that I attended the deceased from 13 Sept. 1958 to 23 Sept. 1958 , that I last saw the deceased alive on 23 Sept. 1958 , and that death occurred at 2:55A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE 		ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 9-23-58			
PHYSICIAN'S NAME (Type) J. C. PARKE, JR. LT MC USN		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7- - -		22c. NAME OF CEMETERY OR CREMATORIAL + m. m.	
22d. LOCATION (City, town, or county) Norfolk, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS 1557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 25 58	
				24b. REGISTRAR'S SIGNATURE 	



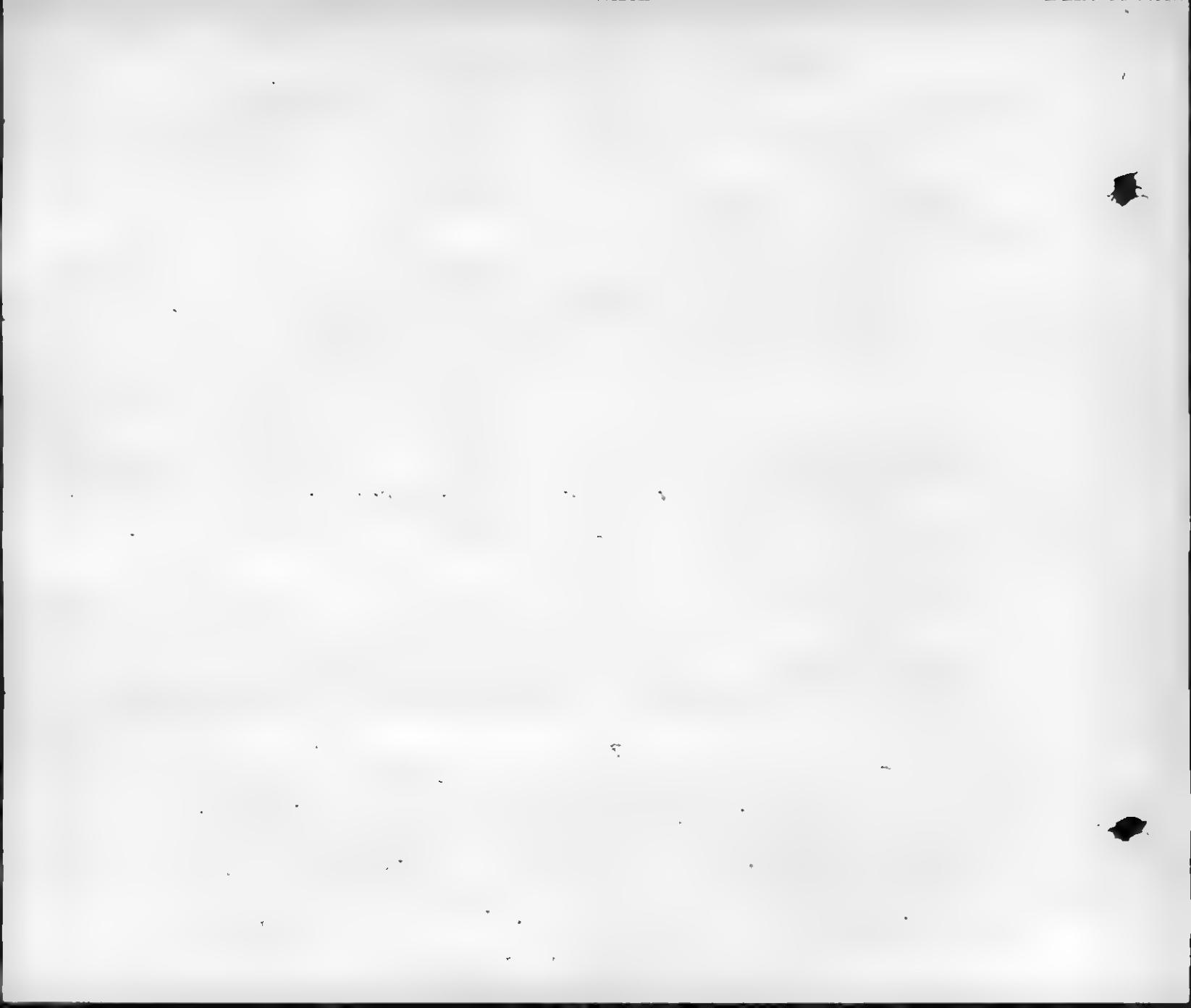
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10294

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>26 Rockville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i>		e. STREET ADDRESS 509 BILSCOT PLACE		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Baby Constance</i>	Middle	Last <i>Cottman</i>	4. DATE OF DEATH 9 - 6 1958	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-58	9. AGE (In years lost birthday) yrs. 9	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS Days 4	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George L. Cottman</i>				14. MOTHER'S MAIDEN NAME <i>Norma Katherine Sullivan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>				16. SOCIAL SECURITY NO <i>Patient's chart</i>			
17. INFORMANT <i>Address</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO <i>Intracranial hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Cause unknown</i>				INTERVAL BETWEEN ONSET AND DEATH <i>30 hr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>909 Vicks Mill Rd</i>		20f. (City or town) (County) Rockville (State) Md.	
21. I certify that I attended the deceased from 7/4 , 19 58 , to 9/6/58 , 19 58 , that I last saw the deceased alive on 9/6/58 , 19 58 , and that death occurred at 200 M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Richard M. Auld</i> M.D. ADDRESS (Street, city or town, state) 909 Vicks Mill Rd DATE SIGNED Richard M. Auld M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/9/58		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond J. Ziska, SILVER SPRING, MD.</i>		ADDRESS <i>2075242 XVS</i>		24e. REC'D BY REGISTRAR DATE SEP 9 '58		24b. REGISTRAR'S SIGNATURE <i>Raymond J. Ziska, SILVER SPRING, MD.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10295

FOR STATE
HEALTH DEPT.

Reg. Dist. No. _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed by the Deputy Medical Examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be given to the funeral director as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park DOA.		c. LENGTH OF STAY IN lb West Hyattsville 1615-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) washington Sanitarium + Hosp. 7981 18th Ave		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Blaine Walker Covington		First	Middle
4. DATE OF DEATH 9 10 1958		Month	Day
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 7-23-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) USA		9. AGE (in years, last birthday) — yrs	
13. FATHER'S NAME Octavius Mc Covington		14. MOTHER'S MAIDEN NAME Regina B. Barbella	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 475X		16. SOCIAL SECURITY NO. 17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) upper Respiratory Infection DUE TO (c)		Address HOSPITAL RECORDS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Fatal developed in bed	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J Broschart		DATE SIGNED 9-10-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-12-58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) (State) MT. OLIVET CEMETERY WASHINGTON DC	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol 2224-Wis. AVE NW		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
		24b. REG STAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11471

10332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 2 days						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle CRAVEN	4. DATE OF DEATH Month SEPT. 16 Day 19 Year 58					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/10					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House man		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VIRGINIA					
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME BLANCHE (Unknown)	12. CITIZEN OF WHAT COUNTRY? U.S.A					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO								
16. SOCIAL SECURITY NO.								
17. INFORMANT								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drama 44 ^{EX} Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Cancer (c) DUE TO Malignant hypertension								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Hour p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Sept 14 , 19 58 , to Sept 16 , 19 58 that I last saw the deceased alive on Sept 15 , 19 58 , and that death occurred at 8:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE G. Bowditch Hunter Jr.								
PHYSICIAN'S NAME (Type) BOWDITCH HUNTER JR.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Crem	22b. DATE THEREOF 9/19/58	22c. NAME OF CEMETERY OR CREMATORIAL HAMILTON Cemetery	22d. LOCATION (City, town, or county) HAMILTON	(State) VA.				
23. FUNERAL DIRECTOR'S SIGNATURE Men & Reed by J. L. Hunt	ADDRESS Leesburg	24a. REC'D BY REGISTRAR 5	24b. REGISTRAR'S SIGNATURE Elmer S. Kraus	DATE Sept 5 58				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use of the burial-troupe permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10333 CERTIFICATE OF DEATH

10296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Nursing Home				d. STREET ADDRESS 7301 23rd Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOHN		First	Middle	Last	4. DATE OF DEATH September 17, 1958.	Month	Day	Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1878	9. AGE (In years lost birthday) 79 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Store clerk		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John Crawford				14. MOTHER'S MAIDEN NAME Thelma Johns.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [Illegible]		17. INFORMANT Mrs Thelma E John -		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33in DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Generalized arteriosclerosis yes								
INTERVAL BETWEEN ONSET AND DEATH 2 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 13, 1958 to Sept 17, 1958 that I last saw the deceased alive on Sept 16, 1958 , and that death occurred at 7:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Silver Spring Md. DATE SIGNED 1917 Seminary Rd. Sept 17, 1958								
ACTUAL SIGNATURE John R. Gees M.D.								
PHYSICIAN'S NAME (Type) Silver Spring Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-58		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.		ADDRESS		24a. REC'D BY REGISTRAR SEP 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10298

10334 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 85 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1015 South 23rd Street			
3. NAME OF DECEASED (Type or print)	First Walter	Middle Wade	Last Davis		
4. DATE OF DEATH September 23	Month September	Day 23	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1894	9. AGE (In years less birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Private Industry		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Walter Oliver Davis		14. MOTHER'S MAIDEN NAME Minnie Prosperi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO WVI 578-24-7820		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary Arteriosclerosis, Acute Leukemia (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30, 1958, to September 23, 1958, that I last saw the deceased alive on September 23, 1958, and that death occurred at 2:35 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Leonard Garren M.D. PHYSICIAN'S NAME (Type) Leonard Garren, M. D. DATE SIGNED 9/24/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 25, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National	
22d. LOCATION (City, town, or county) Arlington, Va.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Drayton		ADDRESS Arlington, Va.		24a. REC'D BY REGISTRAR DATE SEP 25 1958	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

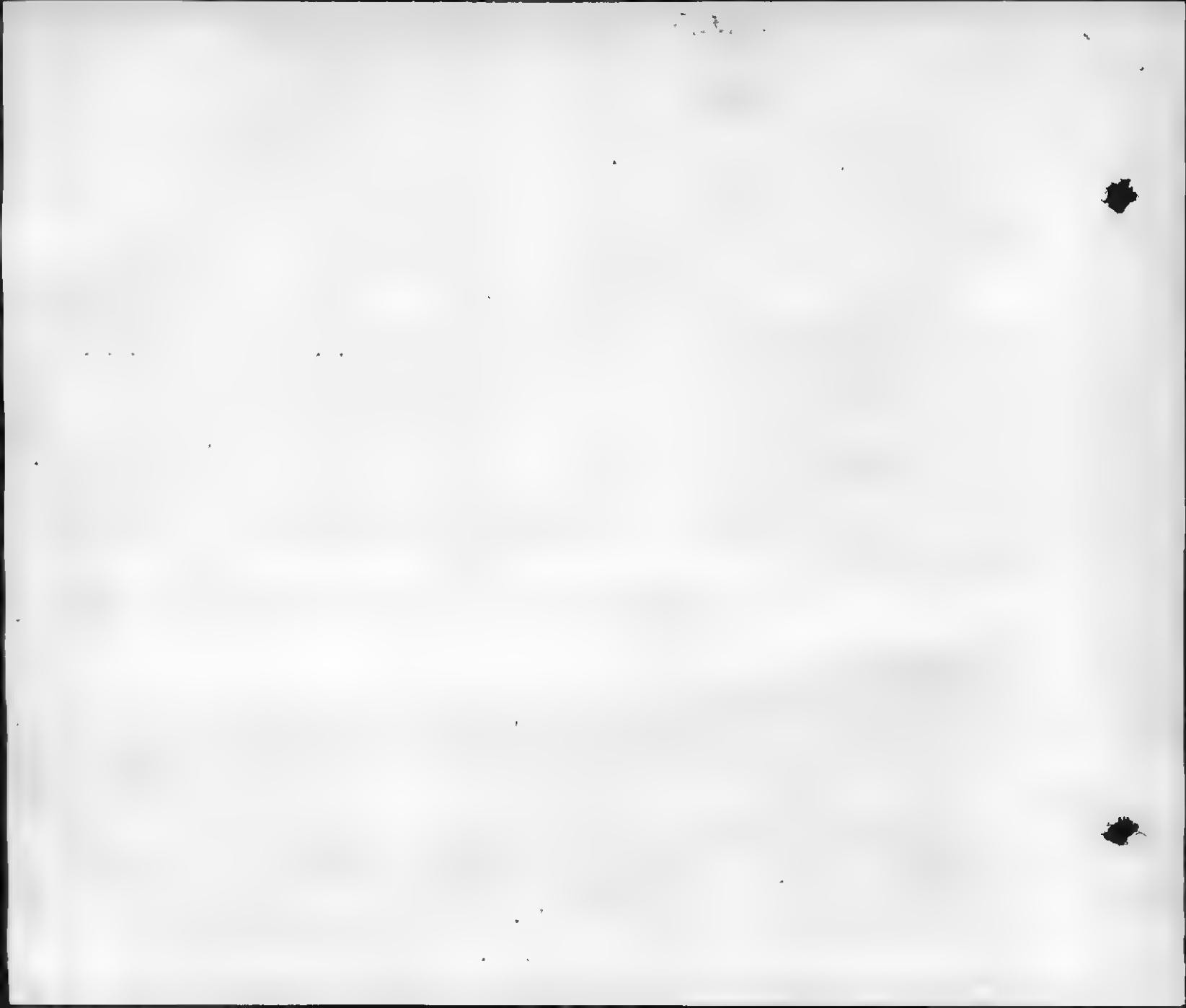
10299

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 14, Film G. 34, 10/6/58 inc				Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY		10335		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING		c. LENGTH OF STAY IN 1b ½ hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2210 PINEY BRANCH RD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4 DATE OF DEATH
RICHARD		HAROLD	FRANCIS	SIXTY EIGHT	Month Day Year SEPTEMBER 29 19 58
5. SEX		6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (in years from birthday)
M		WHITE	WIDOWED	6/29/16	42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
OWNER		RESTAURANT		WASHINGTON, D.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
RICHARD JACOB DITTEL		Matilda Elizabeth Suanay		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		Address	
No		17. INFORMANT		Erwin Dittel 10012 Portland Rd. Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Found dead In rear room of restaurant			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage & Laceration			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Bullet wound thru skull			
(b)					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)			
Self inflicted bullet wound thru skull					
20c. TIME OF INJURY Hour o. m. ? p. m.		Month, Day, Year 9/29/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) SILVER SPRING, MARYLAND, U.S.A. (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE: <i>Frank J. Bruschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/29/58	
EXAMINER'S NAME (Type)		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/1/58		24a. REC'D BY REGISTRAR DATE SEP 30 '58	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond J. Ziska</i>		ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10336

CERTIFICATE OF DEATH

10300

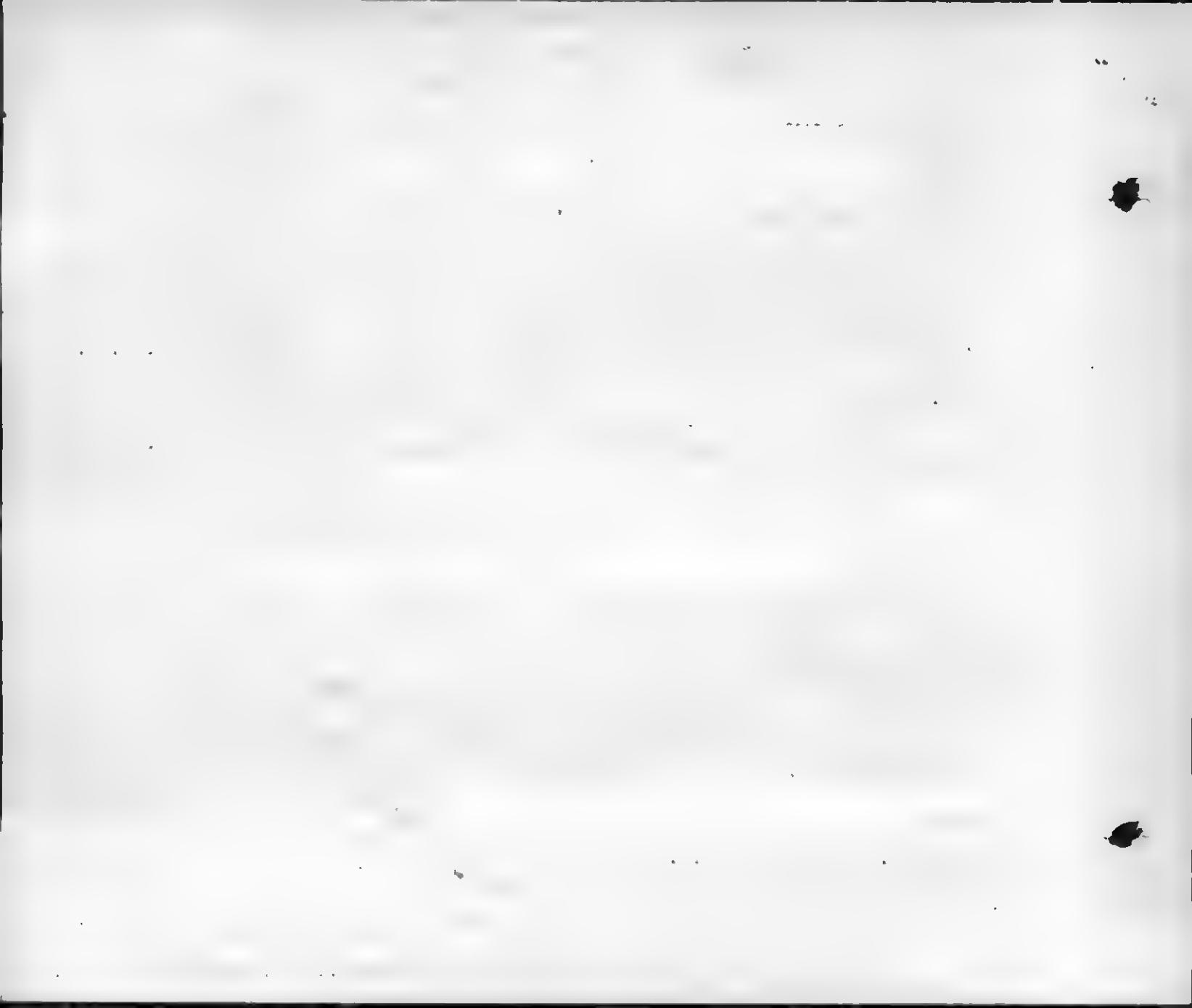
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 156 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4415 Montgomery Avenue	
3. NAME OF DECEASED (Type or print) ROBERTO		First ROBERTO	Middle ITALO
		Lost DONADEI	4. DATE OF DEATH Month September Day 7, Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 30, 1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Translator		10b. KIND OF BUSINESS OR INDUSTRY Argentine Government	9. AGE (In years lost birthday) 38 yrs
11. BIRTHPLACE (State or foreign country) Argentina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Valerio Donadei		14. MOTHER'S MAIDEN NAME Josefa Dapero	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SEC ID# 5679-42-2233	17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 118X DUE TO <i>Tumour carcinoma, primary in Testicle.</i>		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 4, 1958 , to September 7, 1958 , that I last saw the deceased alive on September 7, 1958 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. Richard Lee</i>		M.D. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.		DATE SIGNED (9/8/58)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58	22c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.
22d. LOCATION (City, town, or county) Montgomery County		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PULPHREY		ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR SEP 15 '58
			24b. REGISTRAR'S SIGNATURE <i>Cecil S. Knott</i>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL CHOR: After this certificate has been signed by the attending physician and completely filled in, it should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be left with the funeral director.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10301

FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PN 1, 2, 3, 4, 5 may be retained by the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1.		Reg. Dist. No.										
PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND					a. STATE MD b. COUNTY PG					
b. CITY OR TOWN (If outside corporate limits, write RURAL) and give nearest town)		Takoma Park 3 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Washington San + Hosp.					Hillcrest Hts 1 2110 Keating St.					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (in years, last birthday)		Sept 17 1958		
male		white		<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		3/19/96		62 yrs		IF UNDER 18 YEARS IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)						12. CITIZEN OF WHAT COUNTRY?		
Truck driver		retiree		MD						M.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										
Edward Donaldson		Minnie Emmett										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK		16. SOCIAL SECURITY NO		17. INFORMANT		Address						
(If yes, give year or dates of service) UNK		44K		Hosp Record								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		3 days										
900.0		Rt. Subdural Hematoma and										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO		left central contusion								
(b)		DUE TO		Fracture of skull								
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY		Month Day, Year	20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(City or town)		(County)		(State)	
Hour		9/13 1958	While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		Home		College Rd		P.G.		MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		Frank J. Broehart		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED				
EXAMINER'S NAME (Type)		FRANK J. BROEHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)				
BURIAL		9/20/58		Crown Hill Cem		Baltimore 50 - 7th & Cal. Rd.						
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						
M.W. Chambers		Baltimore MD		SEP 22 '58		Arthur S. Kraus						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10337

CERTIFICATE OF DEATH

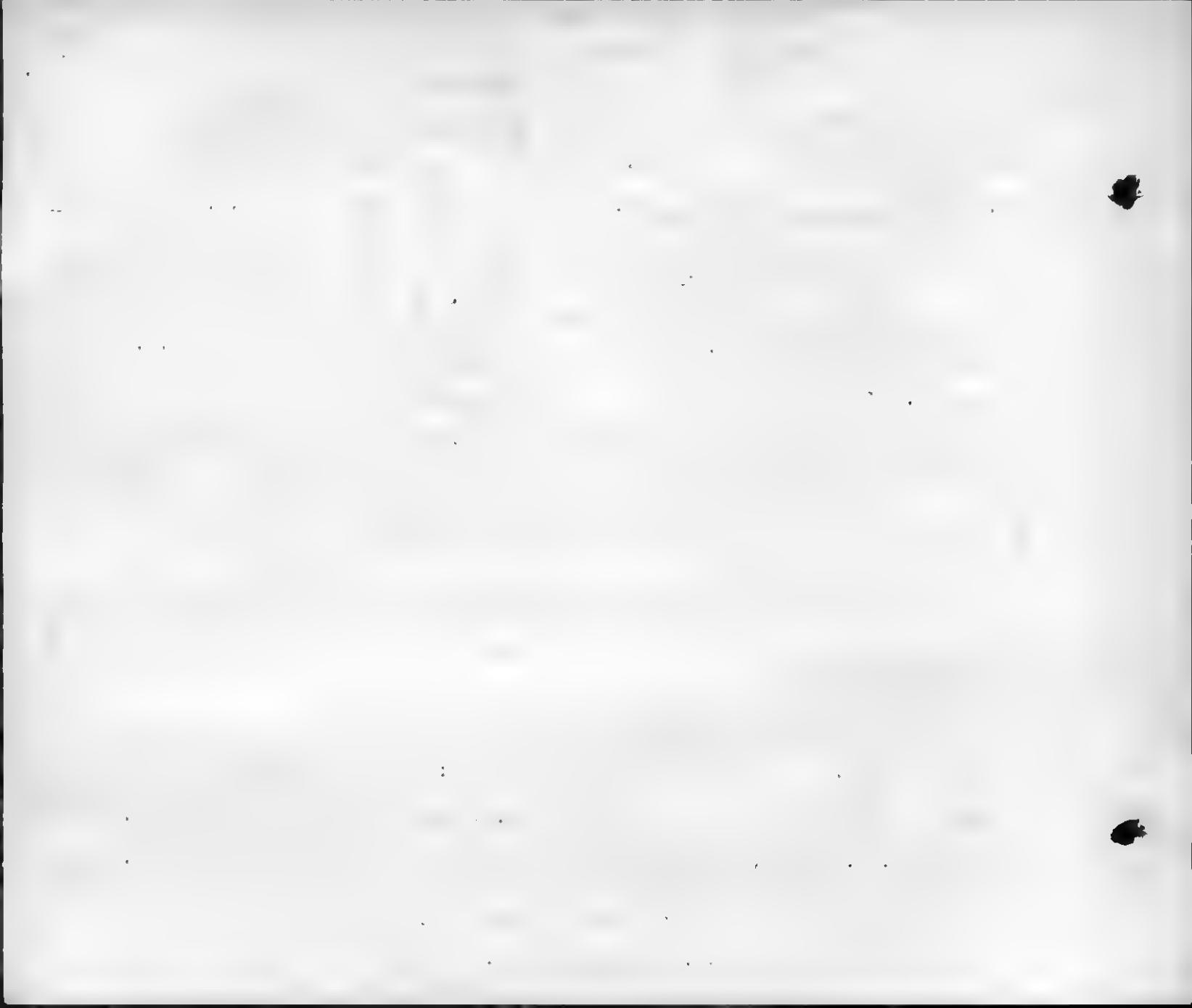
Reg. Dist. No.

10302
215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 mos. 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1214 33rd Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Michael	Last DREA	4. DATE OF DEATH September 8 1958	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1915	9. AGE (In years last birthday) 43 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Wisconsin	
				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Andrew J. DREA					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes 12-19-34 to 6-1-57		16. SOCIAL SECURITY NO 397 30 8785		17. INFORMANT (Wife) Mrs. Audree Virginia DREA (Same As #2)	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bordetella pertussis, left lung DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 21 mos.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 March 1958 to 8 Sept. 1958 that I last saw the deceased alive on 8 Sept. 1958 , and that death occurred at 9:25 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>E.J. Rupnik</i>		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-9-58			
PHYSICIAN'S NAME (Type) E. J. RUPNIK, LCDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) (State)					
Arlington, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.C. Chambers A-391</i>		ADDRESS Chambers, 3072 "M" St., N.W. Washington, D. C.		24a. REC'D BY REGISTRAR SEP 10 '58	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10303

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PAA3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, creation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
Montgomery				a. STATE	md
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY	Montgomery
Silver Spring		9 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Silver Spring
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	2615 Elmore st
2615 Elmore st				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH
George Henry Drury Jr.					Sept 6 1958
5. SEX	6. COLOR OF FACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
Male	white	WIDOWED <input type="checkbox"/>	2-13-84	74 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
advertising		Armour Co		Ind	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Geo. H. Drury		Eliz. Leaverton		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		579-05-4259		Address Marie G. Heintz - Elm 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
420.1 DUE TO Coronary occlusion					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ (b) _____ (c) _____					
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I (o)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
INTERVAL BETWEEN ONSET AND DEATH sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Blosehart</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BLOSEHART		DATE SIGNED 9-6-58			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/58		22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery	
22d. LOCATION (City, town, or county) Montgomery County, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E Lumpkey</i>		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shown detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10339 CERTIFICATE OF DEATH										Reg. Dist. No. 10304	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE Maryland, b. COUNTY Prince George						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First John	Middle	Last Dunn	4. DATE OF DEATH	Month Sept.	Day 20	Year 1958			
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1875	9. AGE (In years from birth) 83 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. MINUTES 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Charlotte N. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Mack Dunn					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Leonie Miller			Address Glenarden, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia 442 X DUUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUUE TO Hypertensive Cardiorenal disease (c)										INTERVAL BETWEEN ONSET AND DEATH 5 days	
19. WAS AUTOPSY PERFORMED? * YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month June	Year 1954	20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Glendale	(County) Baltimore	(State) Md.			
21. I certify that I attended the deceased from June 25, 1954 , to Sept. 20, 1958 , that I last saw the deceased alive on Sept. 20, 1958 , and that death occurred at 3:45 AM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Silver Spring, Md.	DATE SIGNED 9/22/58
ACTUAL SIGNATURE Webster Sewell M.D.											
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/58		22c. NAME OF CEMETERY OR CREMATORIUM Glenarden,			22d. LOCATION (City, town, or county) Glenarden, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sewell											
ADDRESS Rockville, Md.					24a. REC'D BY REGISTRAR SEP 26 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					
VS A15 (4) 15M 9/55											

~~11/21/1978~~

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10340

CERTIFICATE OF DEATH

10305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, give street address) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 4 mo. 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation		d. STREET ADDRESS 12415 Georgia Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle E.	Last Dwyer
4. DATE OF DEATH	Month September	Day 29	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/69
9. AGE (In years last birthday) 88 yrs.	10. IF UNDER 1 YEAR Months 88	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Proprietor	10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME William C. Dwyer	14. MOTHER'S MAIDEN NAME Martha E. Rainne		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT William T. Martin	Address 12611 Georgia Ave., Sil. Sp
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cyanites Bilateral DUE TO 610X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostolic Hyper trophy DUE TO (c) Laryngeal Adenoma			
INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/1/58 to 9/28/58 , that I last saw the deceased alive on 9/24/58 , and that death occurred at 5:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. W. Bird</i> ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		SANDY SPRING, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 2 58	22c. NAME OF CEMETERY OR CREMATORIUM Rockville Union	22d. LOCATION (City, town, or county) (State) Rockville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber	ADDRESS Laytonsville, MD	24a. REC'D BY REGISTRAR DET 3 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10306

10341

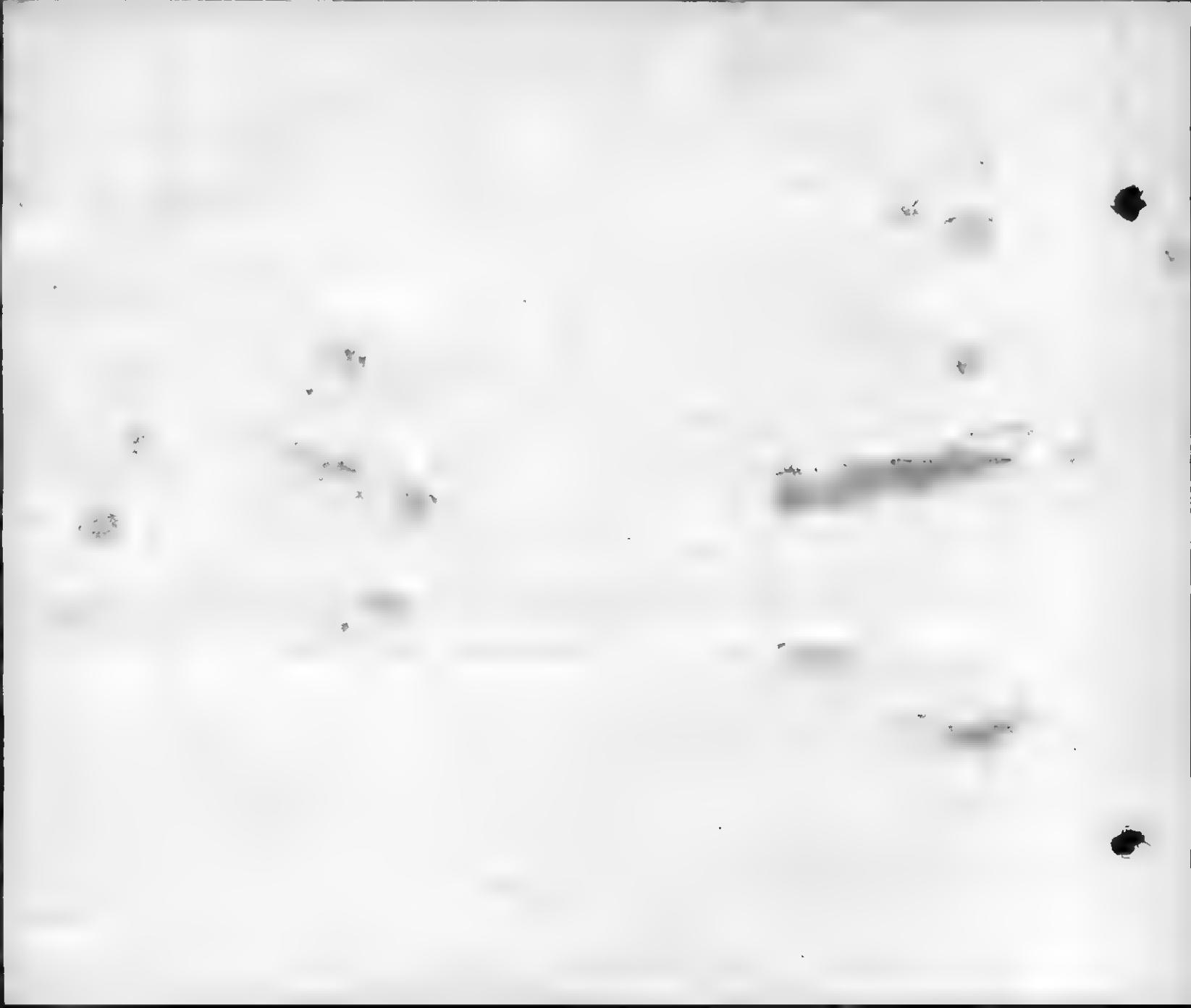
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>8 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>117 Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hosp.</i>				d. STREET ADDRESS <i>117 Takoma Park</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ellie</i>		First <i>Genevieve</i>	Middle <i>Edwards</i>	Last <i>Ellie</i>	4. DATE OF DEATH Month <i>9</i>	Day <i>4</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/22/10</i>	9. AGE (in years last birthday) <i>88</i>	10. IF UNDER 1 YEAR Months <i>0</i>	Days <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Hugh Peden</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Hosp. Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		COPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral vascular accident - rt.		INTERVAL BETWEEN ONSET AND DEATH 1 day		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/27</u> , 19 <u>58</u> , to <u>9-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-3</u> , 19 <u>58</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Ernest A. Sarao Jr.</u> ADDRESS (Street, city or town, state) <u>M.D. 7006 New Hampshire Ave Takoma Park</u> DATE SIGNED <u>9-4-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 7, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Salem Cemetery</i>		22d. LOCATION (City, town, or county) <i>Winston-Salem, North Carolina</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St NW LLC</i>		24a. REC'D BY REGISTRAR DATE <u>SEP 5 '58</u>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

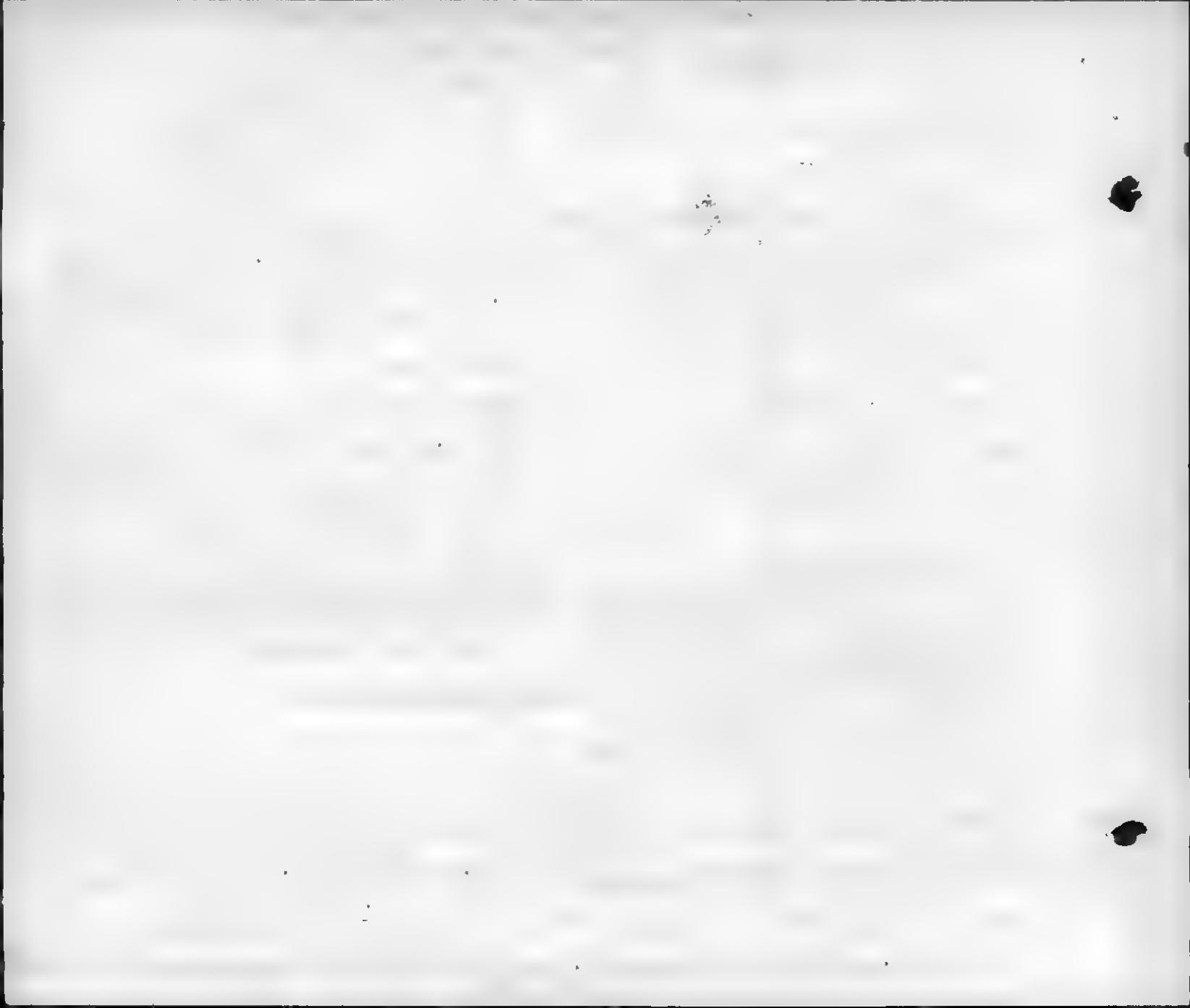
10750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 3410 Shepherd Street				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3410 Shepherd Street				d. DATE OF DEATH Sept. 1,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELEANOR		First	Middle	Last	Month	Day	Year			
4. SEX Female		5. COLOR OR RACE White	6. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	7. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1907	9. AGE (In years less birthday) 51 yrs	10. IF UNDER 1 YEAR Months 0 Days 24	11. IF UNDER 24 HRS. Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME George W. Craven		14. MOTHER'S MAIDEN NAME Martha Arnold								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 530-19-6605		17. INFORMANT Cyrus C. Fishburn-Item		Address 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO ACUTE STOMACH DILATATION		INTERVAL BETWEEN ONSET AND DEATH 14 HOURS						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO INTESTINAL OBSTRUCTION		2-3 WEEKS						
(c)		METASTATIC CARCINOMA, PRIMARY UNDETERMINED UNKNOWN								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. b. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 7720 Wisconsin Ave, Bethesda, Md		20f. (City or town) 7720 Wisconsin Ave, Bethesda, Md		(County) Bethesda	(State) MD	
21. I certify that I attended the deceased from AUG. 14, 1958 , to SEPT 1, 1958 , that I last saw the deceased alive on SEPT 1, 1958 , and that death occurred at 4:00 AM , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) M.D. 7720 Wisconsin Ave, Bethesda, Md	DATE SIGNED 9/1/58	
ACTUAL SIGNATURE <i>John H. Duohy</i>										
PHYSICIAN'S NAME (Type) John H. Duohy		T120 Wis. Ave., Bethesda, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/3/58		22c. NAME OF CEMETERY OR CREMATORIAL Spring Grove		22d. LOCATION (City, town, or county) Cincinnati, Ohio		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

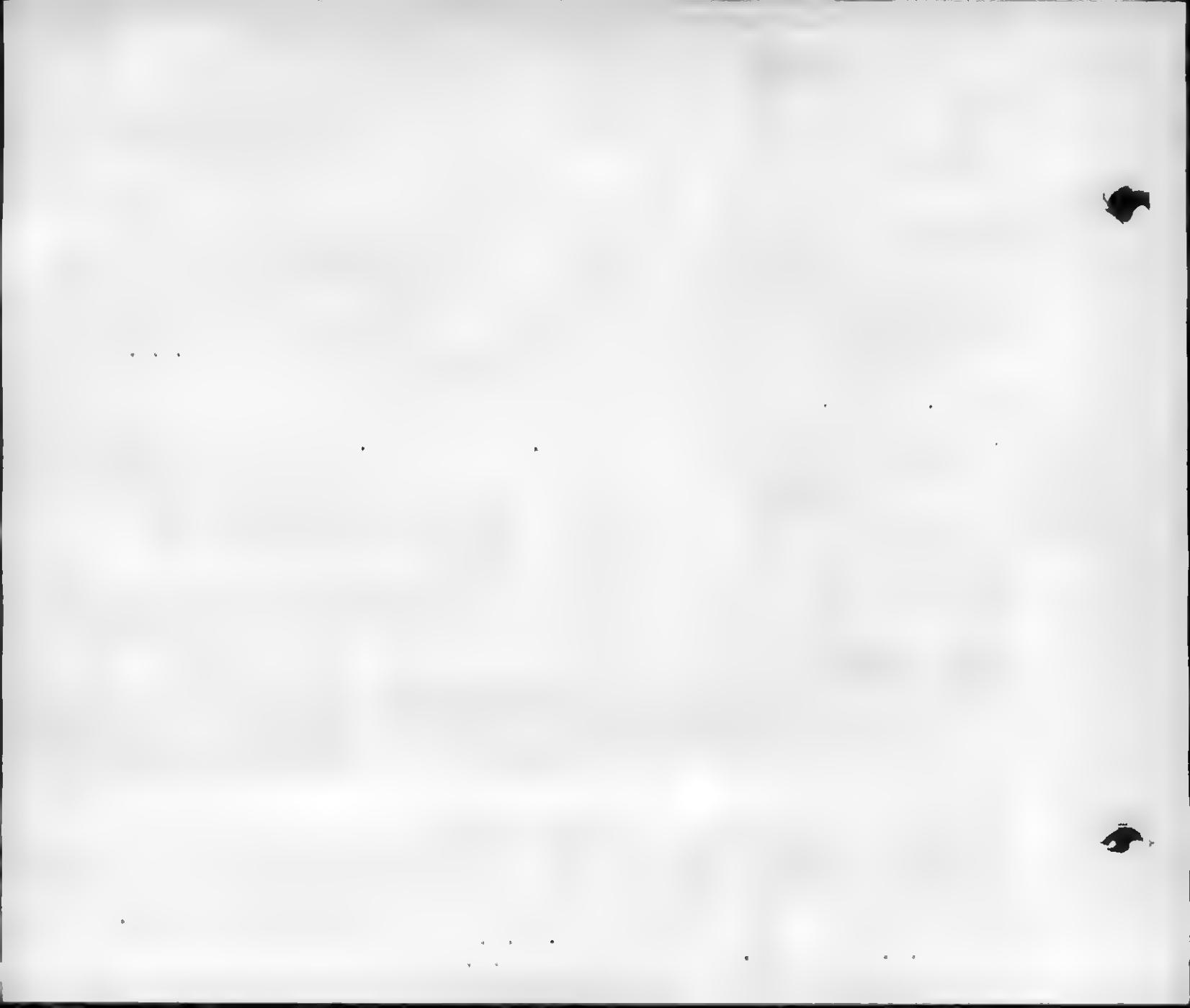
10307

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMQ. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		10343										Reg. Dist. No.	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)											
a. COUNTY		a. STATE Maryland											
Montgomery		b. COUNTY Montgomery											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Bethesda		Chevy Chase											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS											
Suburban Hospital		7400 Summit Avenue											
e. IS RELATIVES ON A FARM?													
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
Emily		Russell		Ford	September	10	1958						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years less birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS						
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	October 9, 1930	27 yrs	Months Days	Hours Min						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housewife				Rome, New York		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Dr. Edwin P. Russell		Mazie Shuler Husband											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
(If yes, give war or dates of service)				W. Kent Ford, Jr.		As above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Edema of larynx											
241X		sudden											
DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Bronchial asthma									
DUE TO		(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Frank J. Borschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type)		Frank J. Borschart								9-10-58			
22a. BURIAL/CREMATION/REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
removal		9/10/58		Mountain View Cemetery		Clifton Forge, Va.							
23. FUNERAL DIRECTOR'S SIGNATURE		2901 14th St. N.W.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
The S.H. Hines Co.		Washington 9, D.C.		DATE SEP 11 '58		Arthur S. Klaus							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10308

10344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington, Md.</i>		b. COUNTY <i>Montgomery</i>					
c. LENGTH OF STAY IN 1b <i>1 yr.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington, Md.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8002 Aurora Drive</i>		d. STREET ADDRESS <i>15002 Aurora Drive</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>INFANT</i>	Middle <i>PHILIP</i>	Last <i>FRANZ</i>				
4. DATE OF DEATH	Month <i>Sept.</i>	Day <i>24</i>	Year <i>1958</i>				
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 4, 1957</i>				
9. AGE (In years lost birthday) yrs. <i>1</i>	10. IF UNDER 1 YEAR Months <i>1</i>	11. IF UNDER 24 HRS. Days <i>20</i>	Hours <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Gerald J. Franz</i>	14. MOTHER'S MAIDEN NAME <i>ELLEN MEEHAN</i>	Address <i>6002 Aurora Dr. Kensington, Md.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>FATHER</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Spontaneous Intracranial Hemorrhage (INDEFINITE)				
INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>NONE</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <i>NONE</i>						
20c. TIME OF INJURY Hour o. m. <i>—</i>	Month <i>Sept.</i>	Year <i>1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 10001 E. BEXHILL Drive</i>	20f. (City or town) <i>Silver Spring, Maryland</i>	(County) <i>Montgomery</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>OctobCK, 1957</i> , to <i>Sept 23, 1958</i> , that I last saw the deceased alive on <i>Sept 23, 1958</i> , and that death occurred at <i>8:15 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James M. Moser Jr.</i>	ADDRESS (Street, city or town, state) <i>JAMES M. MOSER, JR. Kensington, Md.</i>			DATE SIGNED <i>Sept 25 '58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-26-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven</i>	22d. LOCATION (City, town, or county) <i>Silver Spring, Maryland</i>	(State) <i>Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey Funeral Home, Bethesda, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>Arthur S. Thorne</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10309

10345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sonoma Brookdale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Vme 5013 Brookdale Road</i>		e. STREET ADDRESS <i>5013 Brookdale Rd</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ethel Dodge Frost</i>		4. DATE OF DEATH <i>September 26 1958</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1 June 1890</i>
9. AGE (In years last birthday) <i>68 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during time of working life, even if retired) <i>Vme</i>		11. BIRTHPLACE (State or foreign country) <i>Laurel, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>			
13. FATHER'S NAME <i>Carrol DeWittton Frost</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Dodge</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mo</i>	
17. INFORMANT <i>Mr. Helen Robinson (Sister)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of ovary with generalized metastasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 + years</i>	
20a. MEDICAL CERTIFICATION <i>Vme</i>		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i></i>	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i></i>	
20e. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20g. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from _____ April _____, 1958, to 26 Sept _____, 1958, that I last saw the deceased alive on _____ 26 Sept _____, 1958, and that death occurred at 10:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Harry A. Honstman Jr.</i>		ADDRESS (Street, city or town, state) <i>1835 E. West NW Wash. D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-29-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Phillips Church Cem.</i>		22d. LOCATION (City, town, or county) <i>Laurel, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY,</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 30 '58</i>	
ADDRESS <i>Bethesda, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10276

CERTIFICATE OF DEATH

Reg. Dist. No. 10311

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>DC.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	c. LENGTH OF STAY IN 1b <i>4 years</i>	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>111 E. Pratt St.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. STREET ADDRESS <i>111 E. Pratt St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret First Clayton</i>	First <i>E. J. H. Clayton</i>	Middle <i>C. H.</i>	Last <i>Clayton</i>
4. DATE OF DEATH <i>8-17-58</i>	Month <i>Aug</i>	Day <i>17</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 3, 1911</i>
9. AGE (In years last birthday) yrs. <i>47 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
10c. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph C. Clayton</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Edwards Clayton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>415-24-1146</i>	
17. INFORMANT <i>Daughter</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concussion of head - Subdural</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 yrs.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Aug 19 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>Not while at work</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State) <i>None</i>	
21. I certify that I attended the deceased from <i>Aug 16, 1958</i> , to <i>Aug 16, 1958</i> , that I last saw the deceased alive on <i>Aug 16, 1958</i> , and that death occurred at <i>111 E. Pratt St. M.</i> from the causes and on the date stated above ACTUAL SIGNATURE <i>Deborah Clayton</i>		ADDRESS (Street, city or town, state) <i>None</i>	
PHYSICIAN'S NAME (Type) <i>None</i>		DATE SIGNED <i>None</i>	
22a. BURIAL-CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-19-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral 4812 Georgia Ave NW</i>		ADDRESS <i>4812 Georgia Ave NW</i>	
		24a. REC'D BY REGISTRAR DATE <i>SEP 1 7 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10275

CERTIFICATE OF DEATH

Reg. Dist. No.

10310

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park B.R.-20 min		Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Washington Sanitarium & Hospital		412 Ethan Allen Ave.	
e. LENGTH OF STAY IN HB		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FIRE DEPT.			
3. NAME OF DECEASED (Type or print)		First	Middle
John Robert Gallahan		Last	
4. DATE OF DEATH		Month	Day Year
9 - 29 1958			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Male White			8. DATE OF BIRTH
		9. AGE (In years from birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired-Freeman FIRE DEPT.		11. BIRTHPLACE (State or foreign country)	
		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Samuel Gallahan		UNKNOWN ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		HEMORRHAGE, ACUTE, MASSIVE, RETROPERITONEAL 1 DAY	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), listing the underlying cause first.			
(b) RUPTURED ABDOMINAL AORTIC ANEURYSM. DUE TO		1 DAY	
(c) GENERALIZED ARTERIOSCLEROSIS.		YEARS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22, 1958, to Sept. 23, 1958, that I last saw the deceased alive on Sept. 23, 1958, and that death occurred at 11:30 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state), DATE SIGNED	
ACTUAL SIGNATURE A. F. THIBADEAU		M.D. 10111 Callesville Rd., Silver Spring, Md.	
PHYSICIAN'S NAME (Type) A. F. THIBADEAU, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL SEPT. 26, 1958		22c. NAME OF CEMETERY OR CREMATORIUM	
MT. OLIVET CEM.		22d. LOCATION (City, town, or county)	
		WASHINGTON, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Wash. D.C.	
MARTIN W. HYSONG CO. MARTIN W. HYSONG COMPANY		24a. REC'D BY REGISTRAR DATE SEP 25 '58	
		24b. REGISTRAR'S SIGNATURE	
		Clyburn S. Moore	

TO HOSPITAL OR NURSING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the physician or director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10277

CERTIFICATE OF DEATH

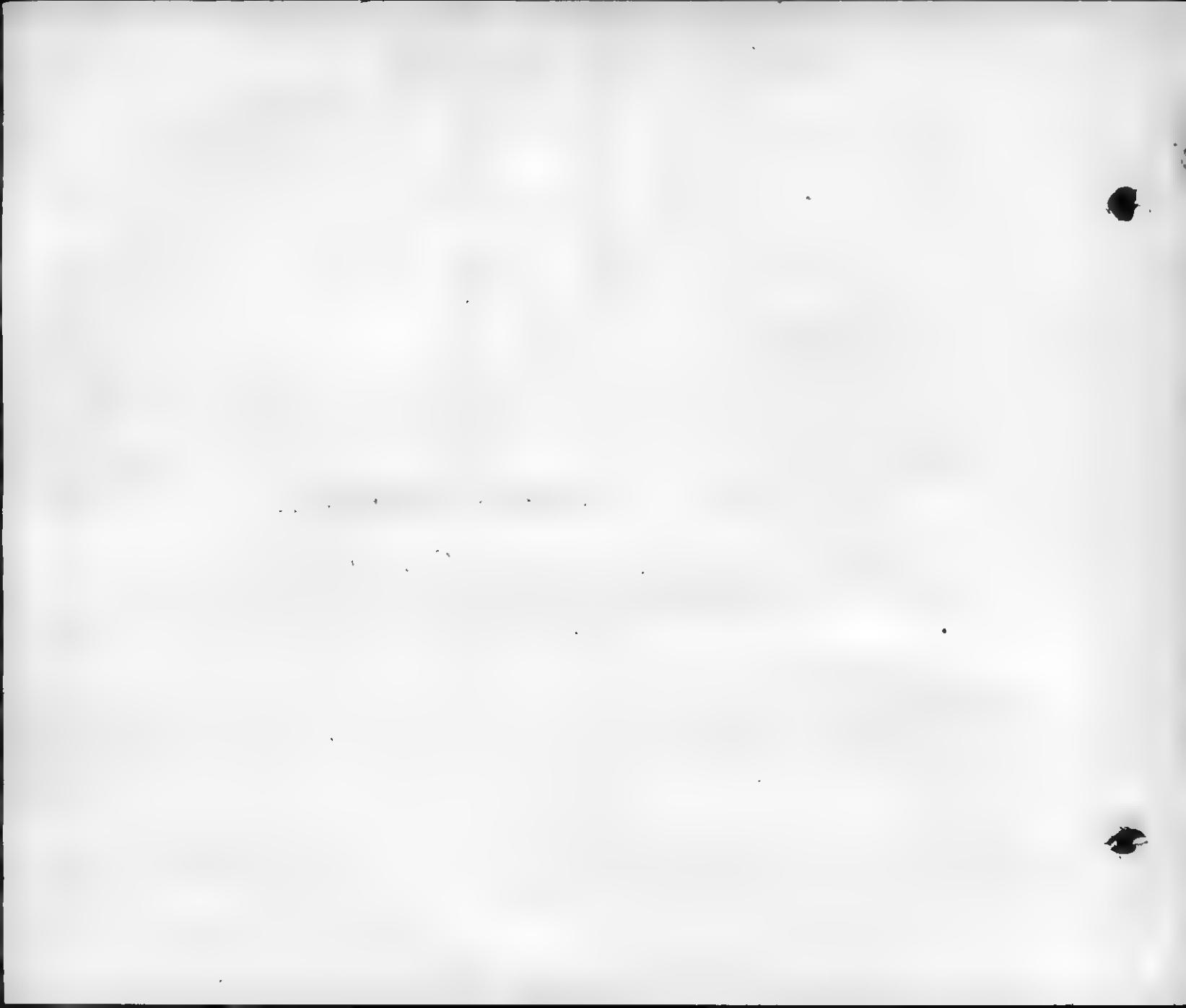
Reg. Dist. No.

10312

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>New York</i>		b. COUNTY <i>i.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>15 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Long Island - Bellmore</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>		d. STREET ADDRESS <i>19-50 270th St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Matthew Frank Gallo</i>		First	Middle	Last	4. DATE OF DEATH <i>9</i>	Month	Day	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>4-25-87</i>	9. AGE (In years last birthday) <i>1 yr.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plasterer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Joseph Gallo</i>		14. MOTHER'S MAIDEN NAME <i>Genevieve Calasie</i>							
15. WAS DECEDAE EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>W W I 117-03-5141</i>		17. INFORMANT <i>Chart</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>900.0</i> DUE TO <i>Buerger-pneumonia terminal</i>						INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>Arteria</i>		(b) <i>DUE TO Primary carcinoma of rectum and/or prostate</i>				3 days			
(c) <i>Multiple fractures due to accident</i>						15 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes, fractures polyuria, hirs. (Diabetic hirsute)</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Pt. fell in home of relatives down basement steps</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>12 30 8-26-58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) (County) (State) <i>Home Takoma Park, Montgomery, Md</i>	
21. I certify that I attended the deceased from <i>8-26-58</i> , 19, to <i>9-10-58</i> , 19, that I last saw the deceased alive on <i>9-9-58</i> , 19, and that death occurred at <i>825</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Reuben F. Clapp M.D. 1600 Carroll Hwy. Takoma Park, Md.</i>		ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i>		DATE SIGNED <i>9-10-58</i>					
22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4-12-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>LONG ISLAND CPM.</i>		22d. LOCATION (City, town, or county) <i>N.Y. NY</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Newell Sons Inc.</i>		ADDRESS <i>1186 R. Ave NW</i>		24a. REC'D. BY REGISTRAR DATE <i>SEPT 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John - Kins</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10313

10346

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 47 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pennsylvania		b. COUNTY					
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Windber							
						d. STREET ADDRESS 1904 Graham Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Thomas		Middle Michael		Last Geiger		4. DATE OF DEATH September 17		Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 14, 1949		9. AGE (In years lost birthday) 8 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas L. Geiger		14. MOTHER'S MAIDEN NAME Helen Dashko											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Staphylococcal Septicemia				INTERVAL BETWEEN ONSET AND DEATH 6 days							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Lymphocytic Leukemia				10 wks.							
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Windber		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 1, 1958 , to September 17, 1958 , that I last saw the deceased alive on September 17, 1958 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE <i>Nathan S. Taylor</i>		M.D.		The Clinical Center		DATE SIGNED 9-17-58							
PHYSICIAN'S NAME (Type) N		Nathan S. Taylor, M. D.		National Institutes of Health Bethesda 14, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 20, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Roman Catholic		22d. LOCATION (City, town, or county) Windber, Somerset Co. Pa. (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Meek</i>		ADDRESS Windber, Penna.		24a. REC'D BY REGISTRAR DATE SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10347

CERTIFICATE OF DEATH

Reg. Dist. No.

10314

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Montgomery</i> MARYLAND		Md. <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>7807-Brikgard Rd.</i>	
e. NAME OF DECEASED (Type or print)		First <i>Samuel</i>	Middle <i>S. Goldberg</i>
		Last <i>J. Goldberg</i>	4. DATE OF DEATH <i>Sept. 27 1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4, 1920</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Aesthetic technician</i>		9. AGE (In years last birthday) <i>38 yrs.</i>	
		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10b. KIND OF BUSINESS OR INDUSTRY <i>Albany, N.Y. M.D.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Albany, N.Y. M.D.A.</i>	
13. FATHER'S NAME <i>Harry Goldberg</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Margulies</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>131-04-1234</i>	
17. INFORMANT <i>Morton Goldberg - 154 Columbia Rd.</i>		18. ADDRESS <i>Cos Cob, Conn.</i>	
19. TIME INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>587.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Major cerebral vascular</i> DUE TO (c) <i>Topic myocarditis</i> DUE TO <i>Licovite Potassium i. p. neovatek</i> 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Tranqu</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) <i>Took</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Rockville</i> (County) <i>MD</i> (State) <i>MD</i>	
21. I certify that I attended the deceased from <i>Sept. 27, 1958</i> , to <i>Sept. 27, 1958</i> , that I last saw the deceased alive on <i>Sept. 27, 1958</i> , and that death occurred at <i>12:56 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Hopkins N. Jones</i> M.D. ADDRESS (Street, city or town, state) <i>Rockville, MD</i> DATE SIGNED <i>Sept. 27, 1958</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>9/28/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>KING DAVID CEMETERY</i>		22d. LOCATION (City, town, or county) <i>FALLS CHURCH, VA</i> (State) <i>VA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gaviles Son & Sons</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 29 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>John S. Knapp</i>	



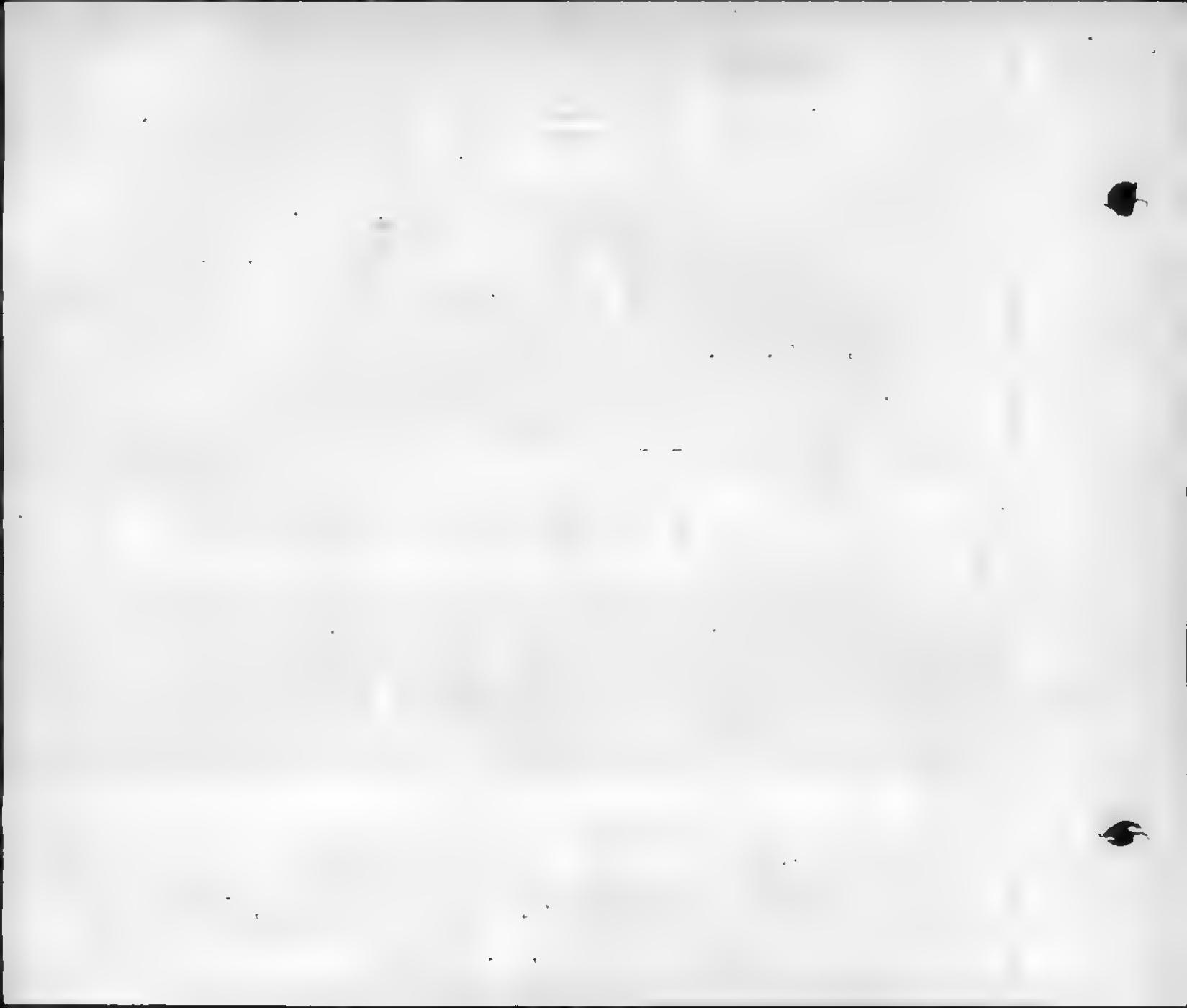
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16315

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed by the medical examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		10348		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		Reg. Dist. No.		
Montgomery		MARYLAND		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MCLELLAN		c. LENGTH OF STAY IN 16 Found dead		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Noewood Rd		d. STREET ADDRESS 13210 Georgia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Maiben Ernest Gordon		First	Middle	lost	DATE OF DEATH	Month	Day	Year
4. SEX Male		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/14	9. AGE (in years from birthday) 24	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Mgr.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John H. Gordon		14. MOTHER'S MAIDEN NAME Christine Mills		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW #2 579-05-7005		17. INFORMANT Lorenzo Bird Gordon		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia		
						DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		
						DUE TO (c)		
						Carbon monoxide poisoning		
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Body badly decomposed. Apparently dead for about 2 wks. when found		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ��e at ached from exhaust extending into car		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/26/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/58		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L Cemetery		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)		
22e. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE <i>Elmer S. Kraus</i>		



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10316

10349		Reg. Dist. No.
<p>1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 1025 226 Grandin Avenue, Rockville</p>
<p>3. NAME OF DECEASED (Type or print) UPTON</p> <p>First MIDDLE LAST</p>		<p>4. DATE OF DEATH September 3 1958</p>
<p>5. SEX Male COLOR OR RACE White MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Nov. 23, 1930</p>		<p>9. AGE (In years from birthday) 27 yrs</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Foreman</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Contracting</p>
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>
<p>13. FATHER'S NAME James Grant</p>		<p>14. MOTHER'S MAIDEN NAME Bessie McKilvey</p>
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes / Marines</p>		<p>16. SOCIAL SECURITY NO. 573-34-9915</p>
<p>17. INFORMANT Hoff-Record</p>		<p>Address</p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 910.5 DUE TO Pulmonary hemorrhage</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Rupture Rt. pulmonary artery</p> <p>(c)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH sudden</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Pushing fallen tree (with bulldozer) which snapped back and hit him.</p>
<p>20c. TIME OF INJURY Month, Day, Year Hour a. m. 9 - 3 1958 While at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/></p>		<p>20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Bethesda (County) Maryland (State)</p>
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>		
<p>ACTUAL SIGNATURE Frank J. Broschart</p>		<p>DATE SIGNED</p>
<p>EXAMINER'S NAME (Type) Frank J. Broschart</p>		<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 9/6/58</p>		<p>22b. DATE THEREOF</p>
<p>22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery</p>		<p>22d. LOCATION (City, town, or county) Rockville, Maryland (State)</p>
<p>23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland</p>		<p>24a. REC'D BY REGISTRAR Arthur S. Kraus DATE SEP 5 '58</p>
		<p>24b. REGISTRAR'S SIGNATURE</p>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PNA3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10317

CERTIFICATE OF DEATH

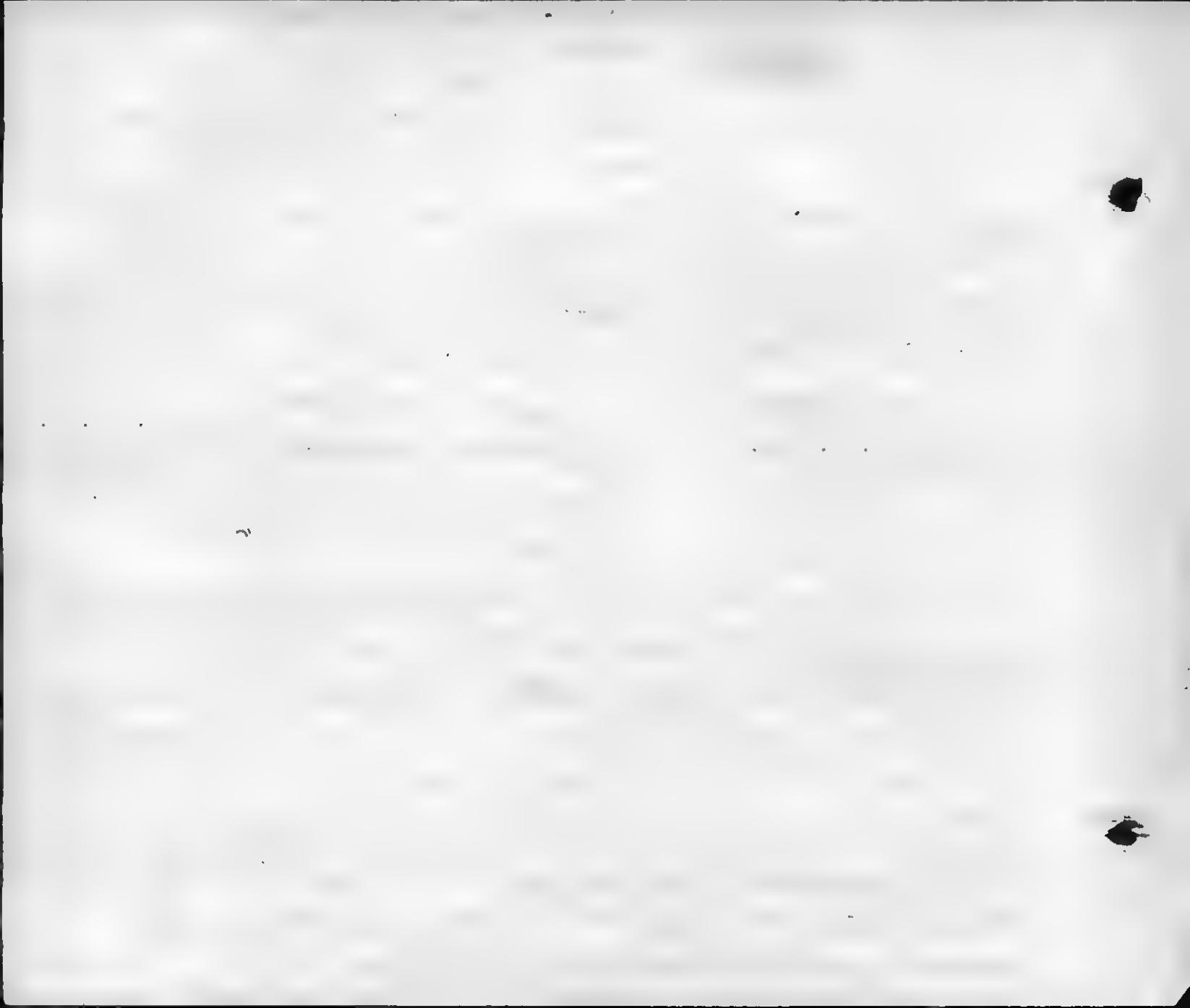
Reg. Dist. No.

10297

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 860 Rockville Pike			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverly Sanitarium				d. STREET ADDRESS 860 Rockville Pike		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM HENRY		First	Middle	Last	4. DATE OF DEATH 9/14/1958	Month	Day	Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 15, 1883	9. AGE (In years from birthday) 75	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Greenleaf				14. MOTHER'S MAIDEN NAME Lane					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO Sp. Am. War. 340-10-0532		17. INFORMANT (daughter) Virginia Greenough		Address 5020 Palisade Lane, Wash., D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH 10 DAYS			
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE		DUE TO GENERALIZED ARTERIOSCLEROSIS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO PARKINSON'S DISEASE				10 YRS.			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PARKINSON'S DISEASE								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington DC		(County)	(State)
21. I certify that I attended the deceased from Aug 5, 1958 to Sept 14, 1958 , that I last saw the deceased alive on Sept 13, 1958 , and that death occurred at 3:45 PM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) M.D. 1835 Eye St NW Washington DC									
DATE SIGNED Sept 14, 1958									
ACTUAL SIGNATURE Hill Carter									
PHYSICIAN'S NAME (Type) HILL CARTER									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-15-1958		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		22d. LOCATION (City, town, or county) Suitland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley Jones		ADDRESS Washington, D. C.		24a. REC'D BY REGISTRAR DATE SEP 16 '58		24b. REGISTRAR'S SIGNATURE C. L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10350

CERTIFICATE OF DEATH

Reg. Dist. No.

10318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 15 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 UNIVERSITY BLVD. WEST		d. STREET ADDRESS 117 UNIVERSITY BLVD. WEST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ARTHUR CECIL GRETTON		First	Middle	Last	4. DATE OF DEATH SEPT. 27 1958	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 21, 1878	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COLLEGIAL ARTIST.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ENGLAND.		12. CITIZEN OF WHAT COUNTRY? ENGLAND.		
13. FATHER'S NAME HENRY GRETTON		14. MOTHER'S MAIDEN NAME WACE.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ✓		16. SOCIAL SECURITY NO. 037-01-7305		17. INFORMANT JOHN C. GRETTON		Address AS ABOVE.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO CORONARY OCCLUSION				INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO CORONARY ATHEROSCLEROSIS				4 YEARS.		
(c)		DUE TO GENERAL ATHEROSCLEROSIS						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov. 1957 , to Sept. 27, 1958 , that I last saw the deceased alive on Sept. 27, 1958 , and that death occurred at 9:51 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE James A. Roberts		ADDRESS (Street, city or town, state) M.D. 8907 GEORGIA AVENUE				DATE SIGNED SEPT 27, 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 9/27/58		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CREMATORIUM		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.		
22e. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Jaska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Collins & Thomas		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10319

10351

CERTIFICATE OF DEATH

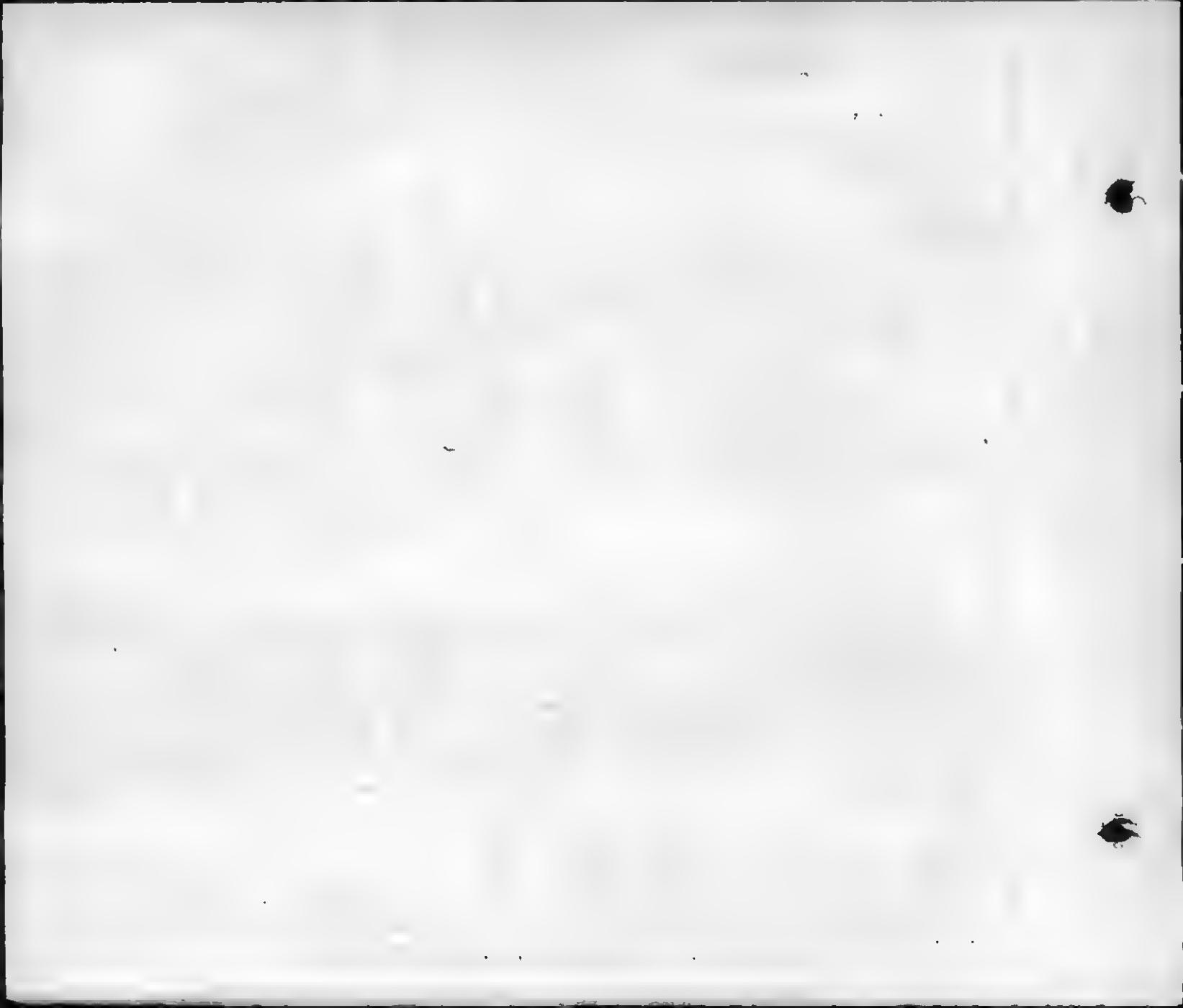
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kentington</i>		c. LENGTH OF STAY IN 1b <i>3 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kentington</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>9536 - E. Beekhill</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Oscar L. Grisamore</i>		First <i>Oscar</i> Middle <i>L.</i> Surname <i>Grisamore</i>		4. DATE OF DEATH <i>Sept. 17, 1958</i>		Month <i>Sept.</i>	Day <i>17</i>	Year <i>1958</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 3 '94</i>		9. AGE (In years last birthday) <i>64 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Eng. Blld.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Thomas Grisamore</i>		14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>WVJ</i>		17. INFORMANT <i>Nelson Grisamore - Son</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)				Caedie Standard II Myocardial infarction Hypertension		INTERVAL BETWEEN ONSET AND DEATH <i>30 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 1302 - 15, N.W., Wash. D.C. 20004</i>		20f. (City or town) <i>Alexandria</i>	(County) <i>Virginia</i>		
21. I certify that I attended the deceased from <i>1955</i> , 19, to <i>Sept. 17, 1958</i> , that I last saw the deceased alive on <i>Sept. 17, 1958</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Alexandria, Virginia</i>		DATE SIGNED <i>Sept. 22, 1958</i>			
ACTUAL SIGNATURE <i>Milton Gusack</i>		PHYSICIAN'S NAME (Type) <i>Milton Gusack</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF <i>9-20-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Presbyterian</i>		22d. LOCATION (City, town, or county) <i>Alexandria, Virginia</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. B. Mountcastle</i>		ADDRESS <i>Cunningham Funeral Home Inc.</i>		24a. REC'D BY REGISTRAR <i>Box 65</i>		24b. REGISTRAR'S SIGNATURE <i>C. John & Sons</i>			
				DATE <i>SEP 22 '58</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10278 CERTIFICATE OF DEATH

10320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>8 mos.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Sanitarium + Hosp.</i>		e. STREET ADDRESS <i>Conn. Ave. + Bradley Lane</i>	
3. NAME OF DECEASED (Type or print) <i>William Gerard Grossbeck</i>		First <i>William</i>	Middle <i>Gerald</i>
3. NAME OF DECEASED (Type or print) <i>William Gerard Grossbeck</i>		Last <i>Grossbeck</i>	4. DATE OF DEATH <i>Sept. 10 1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/1/19</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (State or foreign country) <i>Ohio</i>
11. CITIZEN OF WHAT COUNTRY? <i>America</i>		12. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME <i>Herman J. Grossbeck</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Perry</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>WW NWY None</i>	17. INFORMANT <i>Med. Records</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>13 X</i>		INTERVAL BETWEEN ONSET AND DEATH TERMINAL <i>Congestive Cardiac Failure</i>	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>Broncho-pneumonia</i>		DUE TO <i>1 week</i>	
(b) DUE TO <i>Anemia - Secondary Severe</i>		DUE TO <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bleeding of Bowel-Large.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Takoma Park, Md.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-18- 1958</i> to <i>9-10- 1958</i> that I last saw the deceased alive on <i>9-10- 1958</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare</i>	PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>	ADDRESS (Street, city or town, state) <i>Takoma Park, Md. 9/10/58</i>	DATE SIGNED <i>9/10/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>9/13/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	22d. LOCATION (City, town, or county) <i>Suitland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>	ADDRESS <i>Bethesda, Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 16 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Robert A. Humphrey</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10279

CERTIFICATE OF DEATH

Reg. Dist. No.

10321

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>16 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i>		d. STREET ADDRESS <i>17417 Carroll Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Clara</i>		First	Middle	Last	4. DATE OF DEATH <i>Sept 2 1958</i>	Month	Day	Year
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>Jewish</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3/17/82</i>	9. AGE (In years last birthday) yrs. <i>76</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>		
13. FATHER'S NAME <i>Theodore Brown</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Gadsden</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Hospital Records</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 wks.</i>		
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		(b) <i>Arteriosclerosis</i>				years?		
DUE TO <i>Hypertension</i>		(c)				years?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from <i>1953</i> to <i>Sept 2 1958</i> , that I last saw the deceased alive on <i>Sept 1 1958</i> , and that death occurred at <i>12:15 AM</i> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>M.D. 700 Carroll Ave, Tak. Park, Md. 9/2/58</i>								
DATE SIGNED <i>Robert A. Hare</i>								
ACTUAL SIGNATURE <i>Robert A. Hare</i>		PHYSICIAN'S NAME (Type) <i>Robert A. HARE</i>						
22a. BURIAL/CREMATION, DATE THEREOF REMOVAL (Specify) <i>Burial 9/3-1958</i>		22b. NAME OF CEMETERY OR CREMATORIUM <i>Hat Memorial Park</i>		22d. LOCATION (City, town, or county) <i>Falls Church Va</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wedding Funeral Home</i>		ADDRESS <i>4217 Geer St NW</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 4 1958</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>		



X X X MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10352

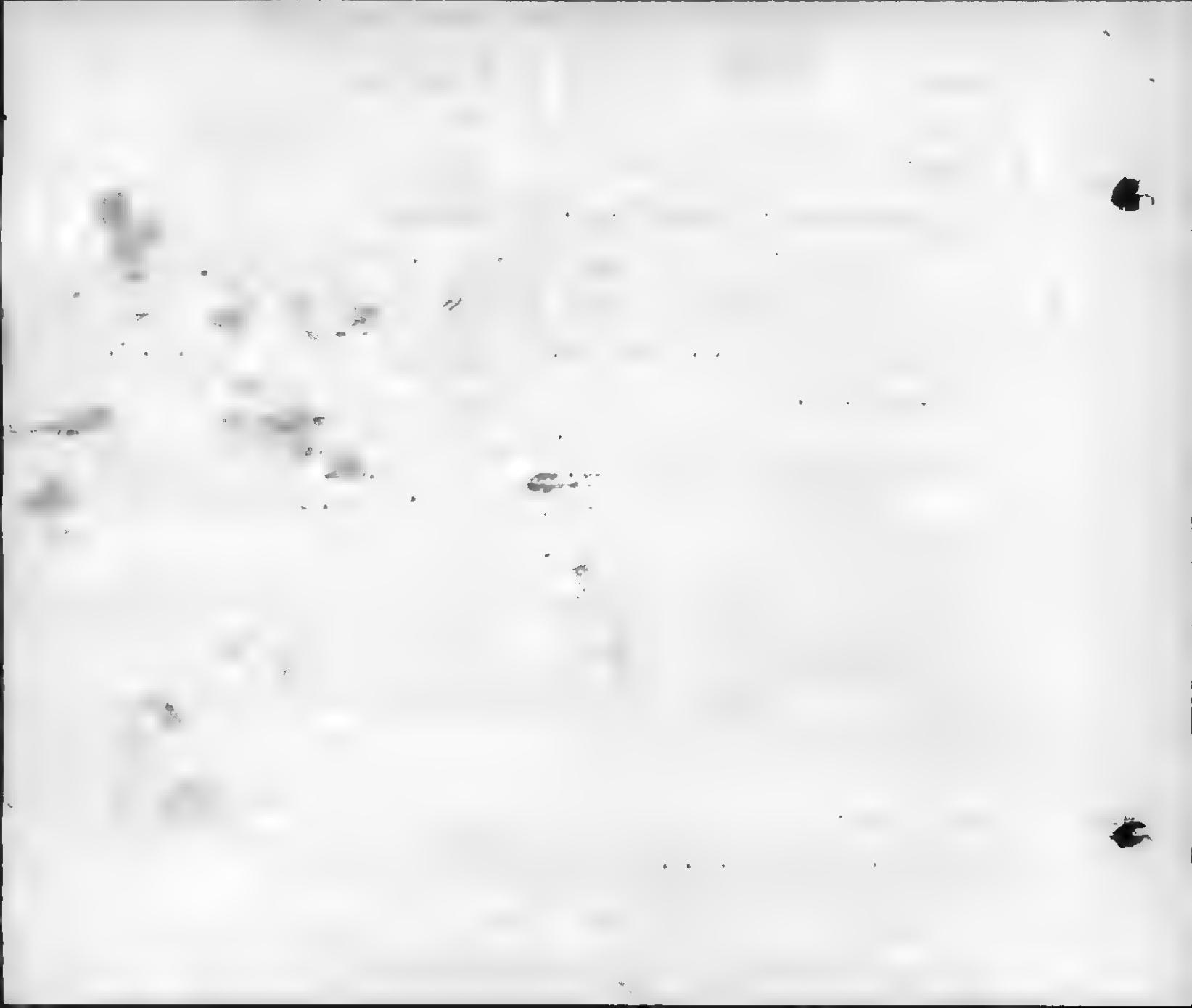
CERTIFICATE OF DEATH

Reg. Dist. No. 10322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Louisiana		b. COUNTY Orleans			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN lb 98 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Orleans					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 2732 Dreux Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First William	Middle (none)	Last Gunn, Jr.	4. DATE OF DEATH	Month September	Day 8,	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 2, 1889	9 AGE (In years last birthday) 68 yrs	10 IF UNDER 1 YEAR Months 9	11 IF UNDER 24 HRS Days 6	Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Supply Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Supply		11. BIRTHPLACE (State or foreign country) Louisiana		12 CITIZEN OF WHAT COUNTRY? U. S. A.			
13 FATHER'S NAME William Gunn, Sr.			14. MOTHER'S MAIDEN NAME Margaret Annie McGary						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO. WWI None		17. INFORMANT The Medical Record Address					
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1/4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last. (b) DUE TO (c)		<i>Carcinoma of the pharynx</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 2, 1958 to September 8, 1958 , that I last saw the deceased alive on September 8, 1958 , and that death occurred at 5:34 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE	<i>G. Richard Lee</i>				M.D.	ADDRESS (Street, city or town, state) The Clinical Center			DATE SIGNED 9/8/58
PHYSICIAN'S NAME (Type)	G. RICHARD LEE, M.D. The National Institutes of Health Bethesda 14, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 9/9/58	22c. NAME OF CEMETERY OR CREMATORIUM Meterie Cemetery		22d. LOCATION (City, town, or county) Orleans Parish, New Orleans		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE <i>Cathy S. Kraus</i>		LA.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10323

10353

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Arkansas		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 75 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stamps		d. STREET ADDRESS 715 N. Opera Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mickey		First Mickey	Middle Sue	Last Hale	4. DATE OF DEATH September 29, 1958	Month September	Day 29	Year 1958	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH November 3, 1939	9. AGE (In years lost birthday) 18 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Paul Cook		14. MOTHER'S MAIDEN NAME Ila Nelle Carroll							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic Shock DUE TO 648.1 INTERVAL BETWEEN ONSET AND DEATH Minutes									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Choriocarcinoma Descentens DUE TO Months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 16, 1958 , to September 29, 1958 , that I last saw the deceased alive on September 29, 1958 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE JACK LEVIN		M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 9/29/58			
PHYSICIAN'S NAME (Type) JACK LEVIN, M.D.		National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 10/2/58		22c. NAME OF CEMETERY OR CREMATORIUM Lake Side Cemetery		22d. LOCATION (City, town, or county) (State) Stamps, Arkansas			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 2 '58		24b. REGISTRAR'S SIGNATURE Living S. Krause			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10324

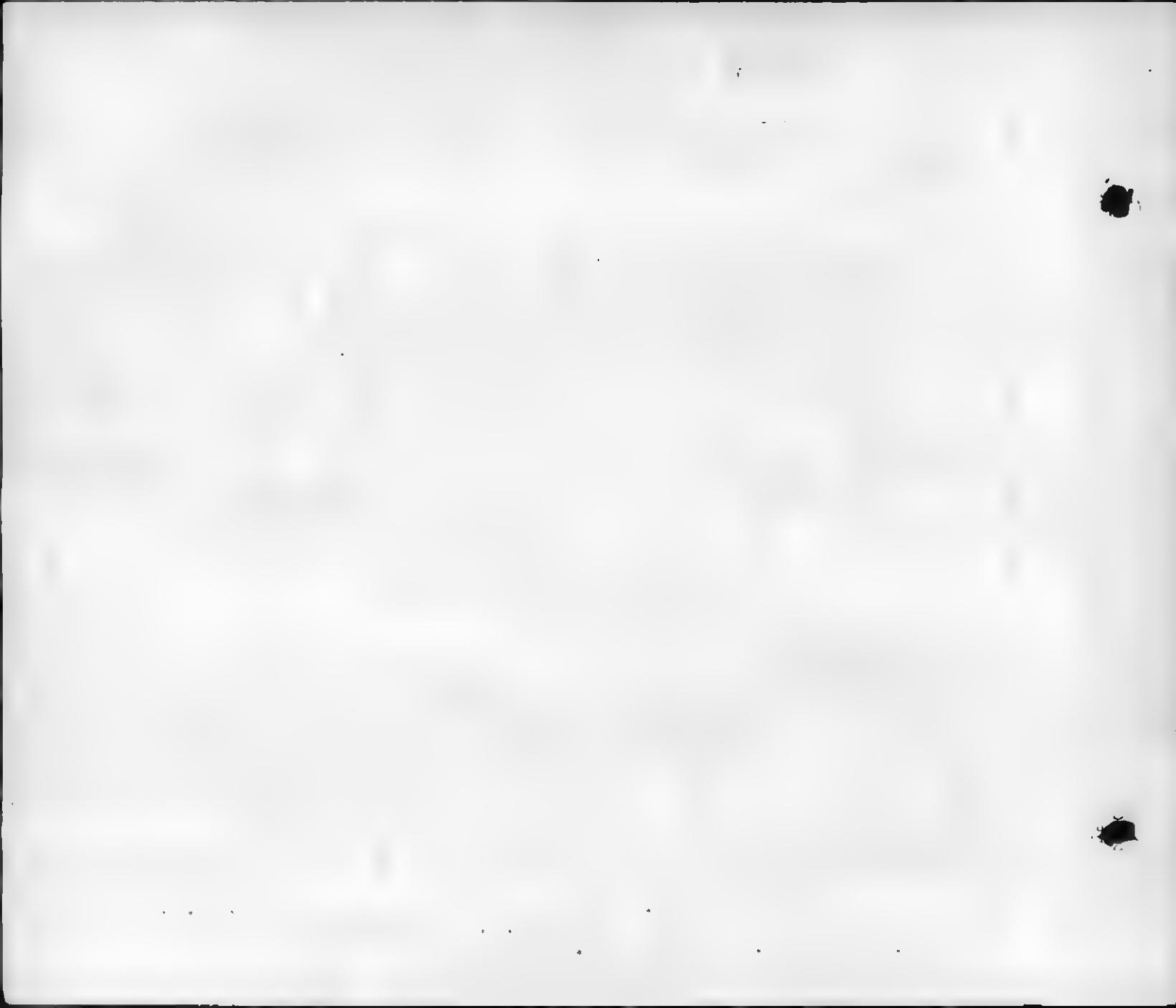
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield		d. STREET ADDRESS 5507 Chesterbrook Road				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) George		First	Middle	Last	4. DATE OF DEATH Sept 10 1958	Month	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 9, 1887	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Evanston Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles J. Hanson		14. MOTHER'S MAIDEN NAME Emma Charlotta Peterson				Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 111-11-1111		17. INFORMANT Clark V. Hanson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS 52.1 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE & FIBRILLATION DUE TO (c) EMPHYSEMA, PULMONARY			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington, D.C.	(County) D.C.	(State) D.C.
21. I certify that I attended the deceased from 8-12 , 1958, to 12:40 9-10 1958 that I last saw the deceased alive on 9-9 , 1958, and that death occurred at 12:40 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Washington, D.C.		DATE SIGNED 9-10-58						
ACTUAL SIGNATURE Philip R. James		M.D. WASHINGTON CLINIC, D.C.								
PHYSICIAN'S NAME (Type) Philip R. James										
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/12/58	22b. DATE THEREOF 9/12/58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Washington, D.C.		(State) D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,		ADDRESS Wash. D.C.	24a. REC'D BY REGISTRAR SEP 11 '58	24b. REGISTRAR'S SIGNATURE Carrie S. Kraus						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10355

CERTIFICATE OF DEATH

10325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN		c. LENGTH OF STAY IN lb 1 mo. 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARYLANDER REST HOME		d. STREET ADDRESS 9516 St. Andrews Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JESSE		First	Middle IRVIN	Lost	4. DATE OF DEATH Month SEPT.	Day 26	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/80	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe salesman self-employed		10b. KIND OF BUSINESS OR INDUSTRY Shoe		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JESSE M. HARR				14. MOTHER'S MAIDEN NAME ANNIE E. WOOD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Miss Edith M. Harr, 9516 St. Andrews Way Address Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 1 Day							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO DUE TO (c)		Anteriosclerotic cardiovascular disease		10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 15, 1958 to Sept. 26, 1958 , that I last saw the deceased alive on Sept. 25, 1958 , and that death occurred at 7:40A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 9/26/58							
ACTUAL SIGNATURE <i>James P. Kerr</i>		PHYSICIAN'S NAME (Type) JAMES P. KERR					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/27/58		22c. NAME OF CEMETERY OR CREMATORIUM ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)	
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond J. Zarka</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 29 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10280

CERTIFICATE OF DEATH

Reg. Dist. No.

10326

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be forwarded with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>59 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7110 Poplar Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>ADA</u>	Middle <u>IRENE</u>	4. DATE OF DEATH <u>Sept. 3 1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1872</u>
9. AGE (In years lost birthday) <u>86 yrs</u>	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard T. Humphrey</u>		14. MOTHER'S MAIDEN NAME <u>Ada Connors</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Marin J. Gates, 629 First Ave. S.S.N.</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause last. (b) <u>Senile arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 & 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>7112 Willow Ave.</u> (County) <u>D.C.</u> (State)	
21. I certify that I attended the deceased from <u>Aug. 25, 1958</u> , to <u>3 Sept. 1958</u> , that I last saw the deceased alive on <u>25 Aug. 1958</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>H.B. Queen</u> M.D. <u>7112 Willow Ave.</u> ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>3 Sept. 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 5, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trahan</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

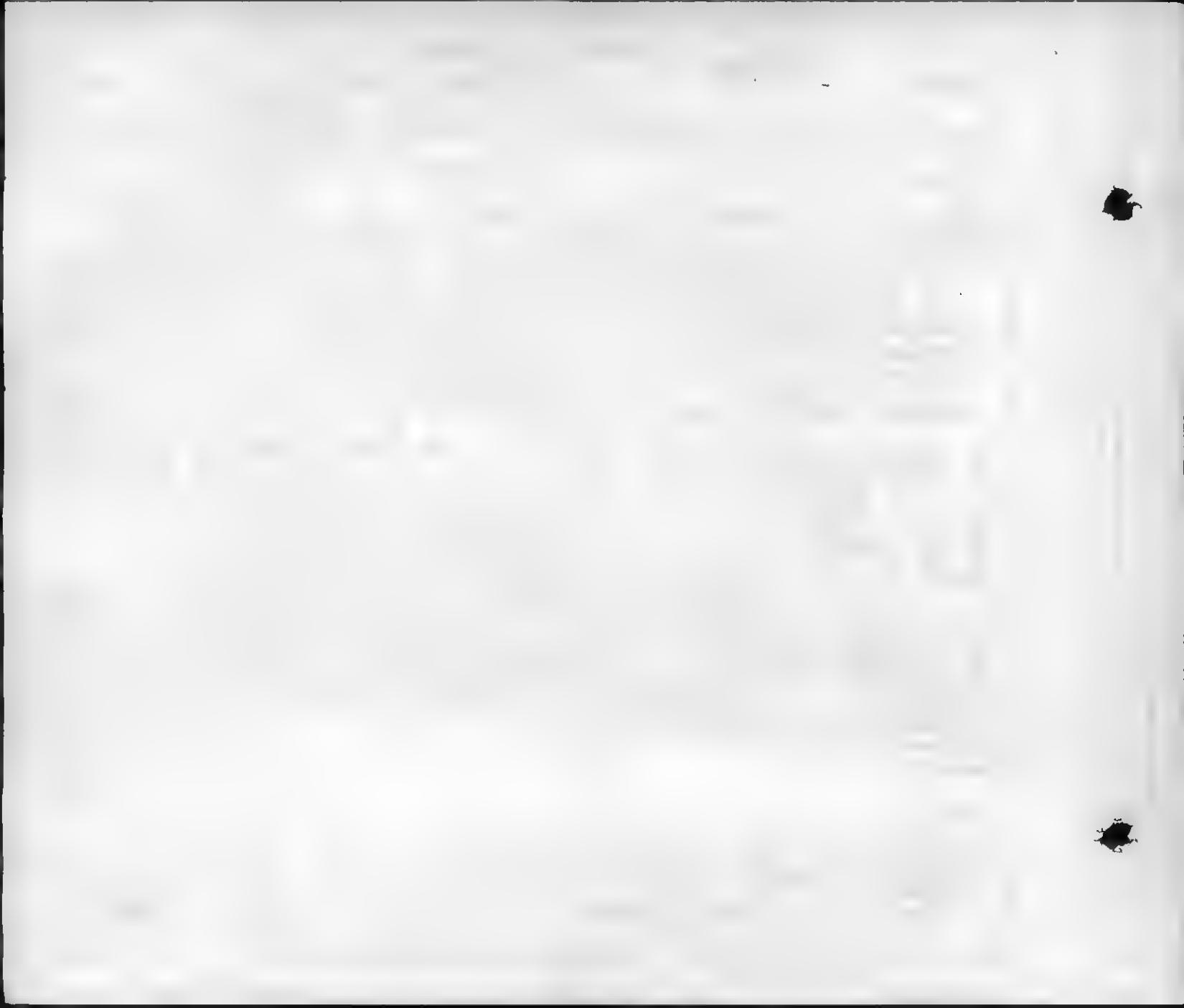
Item 7, Film G234, 10/9/58

10327

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>15 days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET ADDRESS <i>Silver Spring</i>		f. STREET ADDRESS <i>10411 Hayes Ave.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Alta Fox Hattley</i>		First <i>A</i>	Middle <i>l</i>	Last <i>ta</i>	4. DATE OF DEATH <i>Sept 19 1958</i>	Month <i>Sept</i>	Day <i>19</i>	Year <i>1958</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>25 March 1892</i>	9. AGE (In years last birthday) <i>66 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State, or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Stephen J. Johnson</i>			14. MOTHER'S MAIDEN NAME <i>SARAH. J. Lee</i>		Address <i>Home of Hattley 10411 Hayes Ave, Silver Spring, Md.</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Home of Hattley 10411 Hayes Ave, Silver Spring, Md.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vascular accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Generalized progressive arteriosclerosis</i> DUE TO (c) <i></i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1952, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at _____, 1958, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Mary E. L. White</i> M.D. ADDRESS (Street, city or town, state) <i>11134 Georgia Ave Silver Spring, Md.</i> DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>9/26/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>WOODLAND CEMETERY</i>		22d. LOCATION (City, town, or county) <i>VAN Wert, OHIO</i>		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deaf General Hospital 4812 Ga. Ave.</i>		ADDRESS <i>Washington, D.C.</i>		24a. REC'D BY REGISTRAR DACT 3 '58		24b. REG STRR'S SIGNATURE <i>Orchard St. House</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10357

CERTIFICATE OF DEATH

Reg. Dist. No.

10328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b 2708 FINCH STREET		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2708 FINCH STREET		d. STREET ADDRESS 2708 FINCH STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		Middle THERESA	Last HAWKINS
4. DATE OF DEATH Month SEPT.	Day 3	Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/74
9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FREDERICK B. KAUS		14. MOTHER'S MAIDEN NAME JULIA WHALEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Mr. Paul E. Hawkins, 2708 Finch St.
		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 Hrs.	
/X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		CEREBRAL HEMORRHAGE	
		HYPERTENSION, ARTERIAL	
		20. DUE TO 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS, GENERALIZED		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN. 1957 to 3 SEPT. 1958 , that I last saw the deceased alive on 3 SEPT. 1958 , and that death occurred at 3 P.M. from the causes and on the date stated above ACTUAL SIGNATURE LBSnow		ADDRESS (Street, city or town, state) 9013 FLOWER AVE	
22. PHYSICIAN'S NAME (Type) L. B. SNOW		DATE SIGNED 9/4/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/5/58	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMETERY
22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Humphrey, SILVER SPRING, MD.		24a. ADDRESS SILVER SPRING, MD.	24b. REC'D BY REGISTRAR DATE SEP 5 '58
		24c. REGISTRAR'S SIGNATURE Carlton S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10329

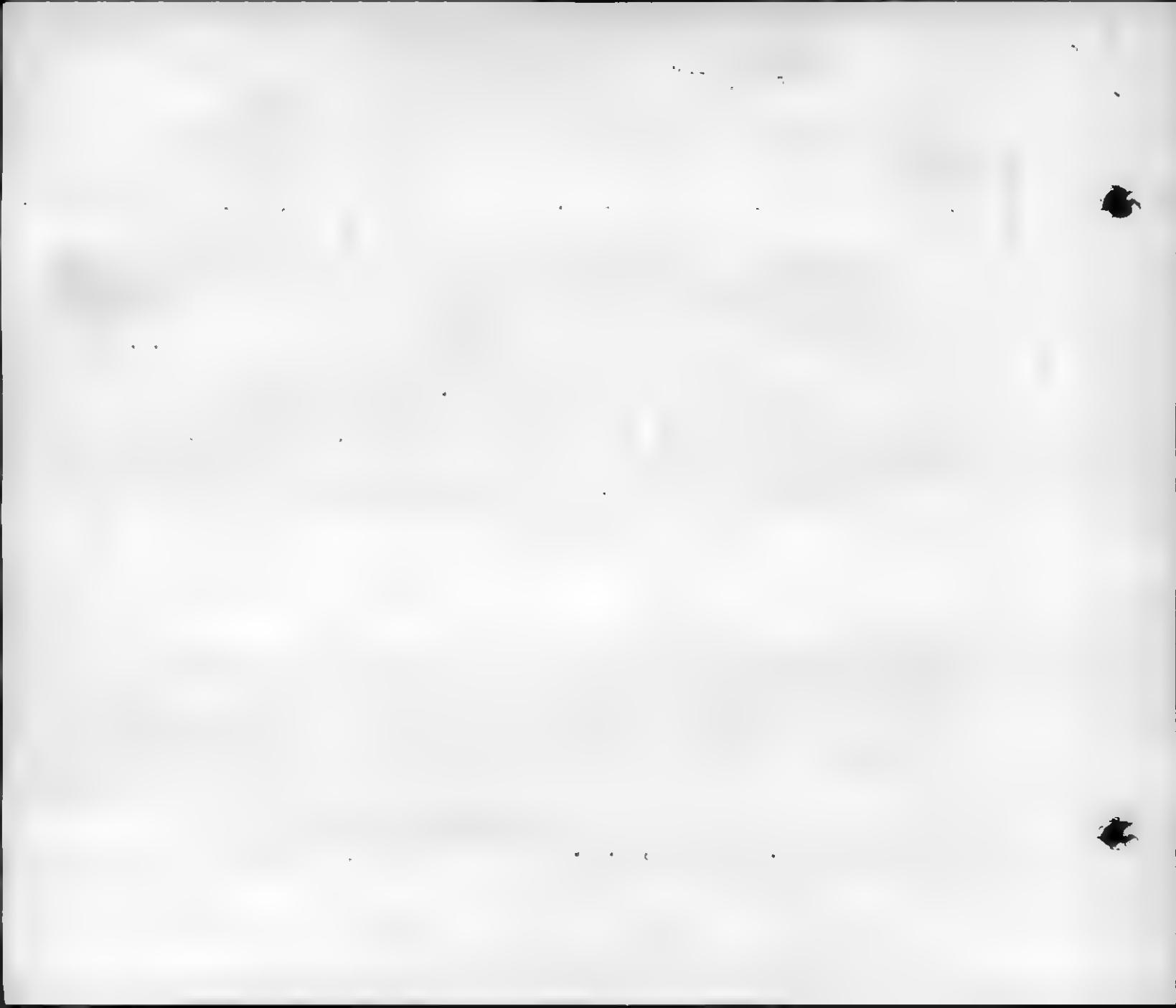
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4001 8th Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Gerald	Middle Jameson	Last Hayden	4. DATE OF DEATH September 14	Month Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 27 December 1942	9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Leo Hayden			14. MOTHER'S MAIDEN NAME Mary V. Jameson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 1958 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)			Pulmonary insufficiency Widespread pulmonary metastases 2 mo. Rhabdomyosarcoma, Et chest wall 9 mo.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from August 23, 1958 , to September 14, 1958 , that I last saw the deceased alive on September 14, 1958 , and that death occurred at 10:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland								
ACTUAL SIGNATURE <i>Harold R. Silberman</i>		DATE SIGNED 9/15/58						
PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Neth. Cem.		22d. LOCATION (City, town or county) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambless, Inc.		ADDRESS 517-11 St. S.E.		24a. REC'D BY REGISTRAR SEP 1 7 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10330

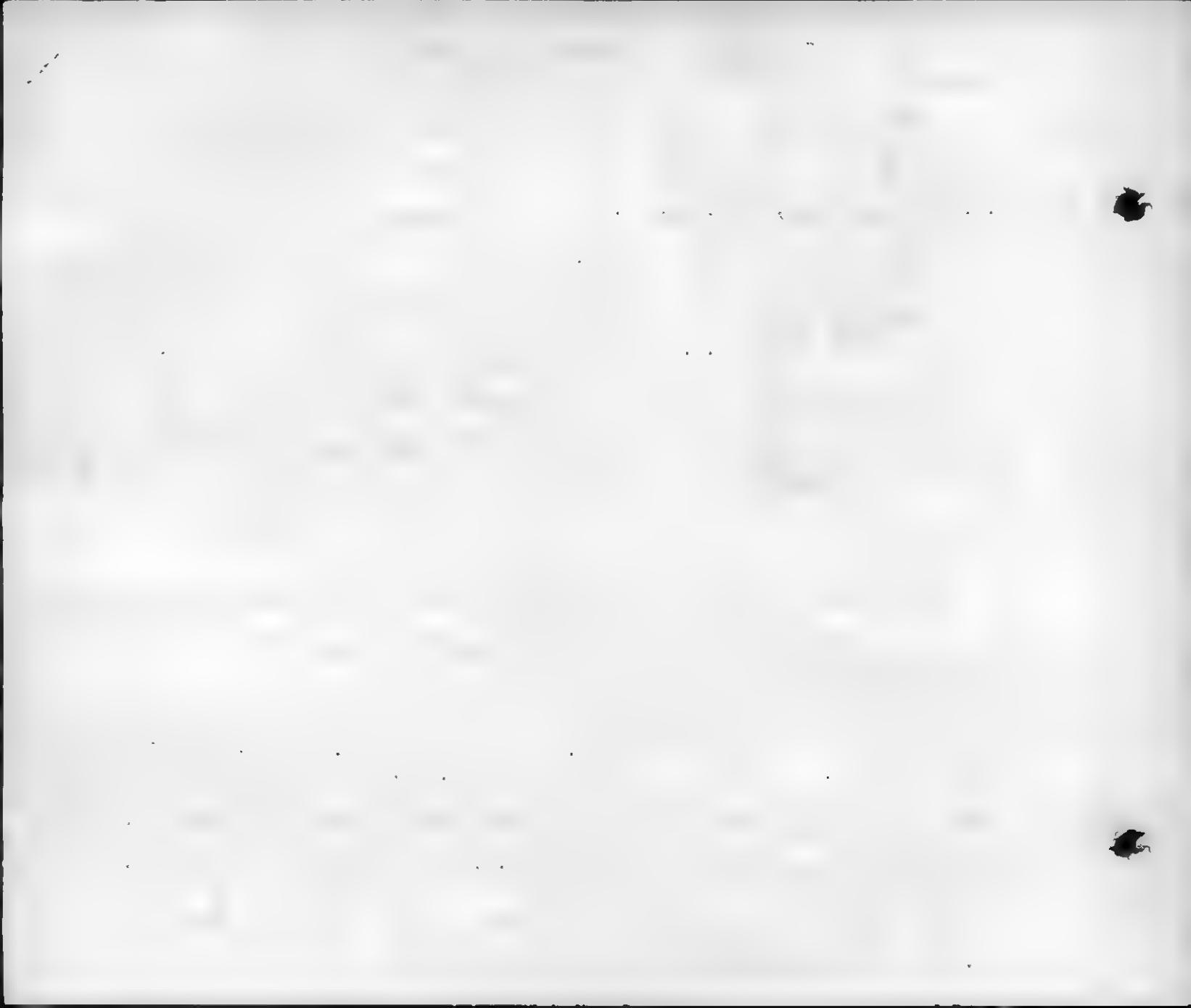
10359

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page **1** may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Georgia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Covington		d. STREET ADDRESS 824 Monticello	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charlie	Middle Morriel	Last HEAD	4. DATE OF DEATH September 14 1958	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 October 1937	9. AGE (in years last birthday) 20	IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 20	Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charlie Manuel HEAD				14. MOTHER'S MAIDEN NAME Ophelia STAPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes, Currently		16. SOCIAL SECURITY NO. 254 50 5034		17. INFORMANT (Wife) Mrs. Sharon Lucille HEAD (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 199.2 DUE TO Carcinomatosis, diffuse INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO primary site unknown 3 WKS (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Sept. 1958 to 14 Sept. 1958 , that I last saw the deceased alive on 14 Sept. 1958 , and that death occurred at 3:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Robert G. Galbraith, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md. DATE SIGNED ACTUAL SIGNATURE Robert G. Galbraith, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md. 9-15-58							
PHYSICIAN'S NAME (Type) Robert G. Galbraith, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORIUM Lawnwood Cemetery		22d. LOCATION (City, town, or county) (State) Covington, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS H-371 1400 Chapin St. Washington, D.C.		24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE Ernest S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

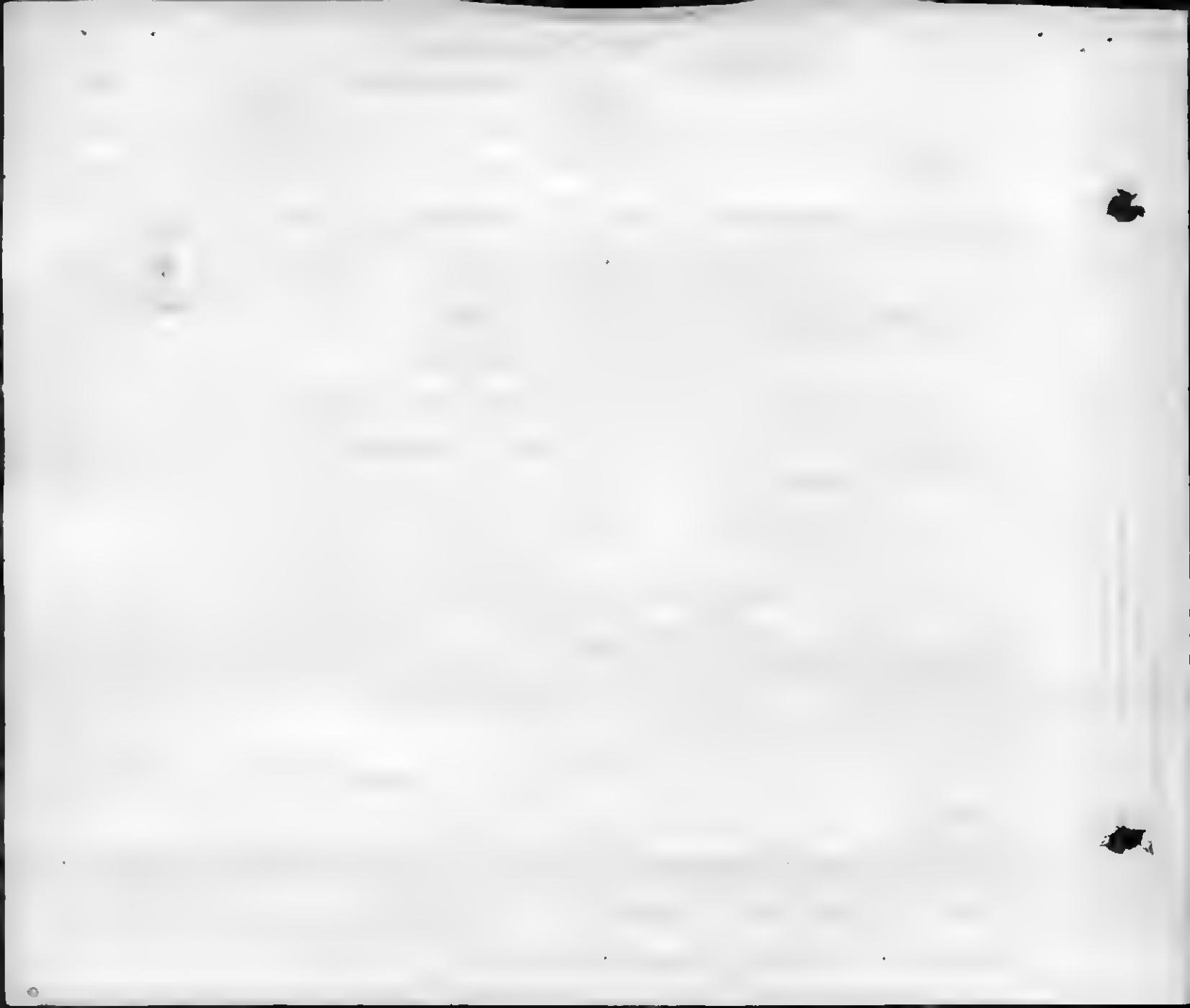
10331

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5525 Prospect Street		d. STREET ADDRESS 5525 Prospect Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EVELYN	Middle A.	Last HEARN	4. DATE OF DEATH Month Sept.	Month 10	Day 19	Year 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 6/20/1880	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months 2	Days 20	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Archie H Asquith		14. MOTHER'S MAIDEN NAME Mary Rutherford		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wilfred Hearn-husband-same as item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1949, to _____, 1958, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Andrew G. Preindoni M.D. 1150 Conn. Ave. NW Wash. 6, D. C.							
ACTUAL SIGNATURE Andrew G. Preindoni		DATE SIGNED 9/10/58					
PHYSICIAN'S NAME (Type) Andrew G. Preindoni		1150 Conn. Ave. N. W. Wash. 6, D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/12/58		22c. NAME OF CEMETERY OR CREMATORIUM Edgehill Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10361

CERTIFICATE OF DEATH

Reg. Dist. No.

10332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and **immediately** filled in, it should be detached for use as the burial transit permit. Then **remove** carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 131 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29,		f. STREET ADDRESS 4904 Stafford Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle Harry	Last Hilgeman	4. DATE OF DEATH September 21 1958	Month September	Day 21	Year 1958		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1888	9. AGE (in years last birthday) 69 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 69	Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Chief		10b. KIND OF BUSINESS OR INDUSTRY Fire fighting		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Frederick G. Hilgeman		14. MOTHER'S MAIDEN NAME Mary Huiss							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 212-28-8222		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		SUB-DURAL HEMORRHAGE, DEXT. side		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO CARCINOMA OF MAXILLARY ANTRUM & LOCAL EXTENSION TO SKULL, + GENERALIZED METASTASIS.		10 Mon. /					
(b)		DUE TO							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 13, 1958 , to September 21, 1958 , that I last saw the deceased alive on September 21, 1958 , and that death occurred at 7:45 PM , from the causes and on the date stated above							ADDRESS (Street, city or town, state)	DATE SIGNED 9/22/58	
ACTUAL SIGNATURE <i>Marvin Romsdahl</i>		M. D. The Clinical Center National Institutes of Health Bethesda 14, Maryland							
FIRM/CAPTE NAME (Type) Marvin Romsdahl, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/58		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Balto. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		ADDRESS		24a. REC'D BY REGISTRAR SEP 25 '58		24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10333

10362

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission)	
Montgomery MARYLAND		a. STATE	Md.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Silver Spring		Montgomery	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
56 days		56 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION		d. STREET ADDRESS	
365 Heron Drive		1805 Heron Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Charles F.			Hoffman Jr.
4. DATE OF DEATH	Month	Day	Year
	9	-	10 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	1/17/1891
9. AGE (In years less b'day)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours M.n.
26 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
RETIRED		US. NAVYYARD WASH, DC.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
CHARLES F HOFFMAN SR		LAURA STEWART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
DOROTHY YOUNG 805 HERON SIL SPG MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsons Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour B. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 July 1958, to 10 Sept. 1958, that I last saw the deceased alive on 9 Sept. 1958, and that death occurred at 9 ¹³ AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. B. Queen</i>		ADDRESS (Street, city or town, state) 7112 Willow Ave Takoma Park, MD DATE SIGNED 10 Sept 1958	
PHYSICIAN'S NAME (Type) J. B. QUEEN		22d. LOCATION (City, town, or county) ROCKVILLE MD (State)	
22b. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 9-12 58		22c. DATE THEREOF 1480 CHAPIN ST plus SEP 15 '58	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO.		24a. RECEIVED BY REGISTRAR Arthur S. Krause	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

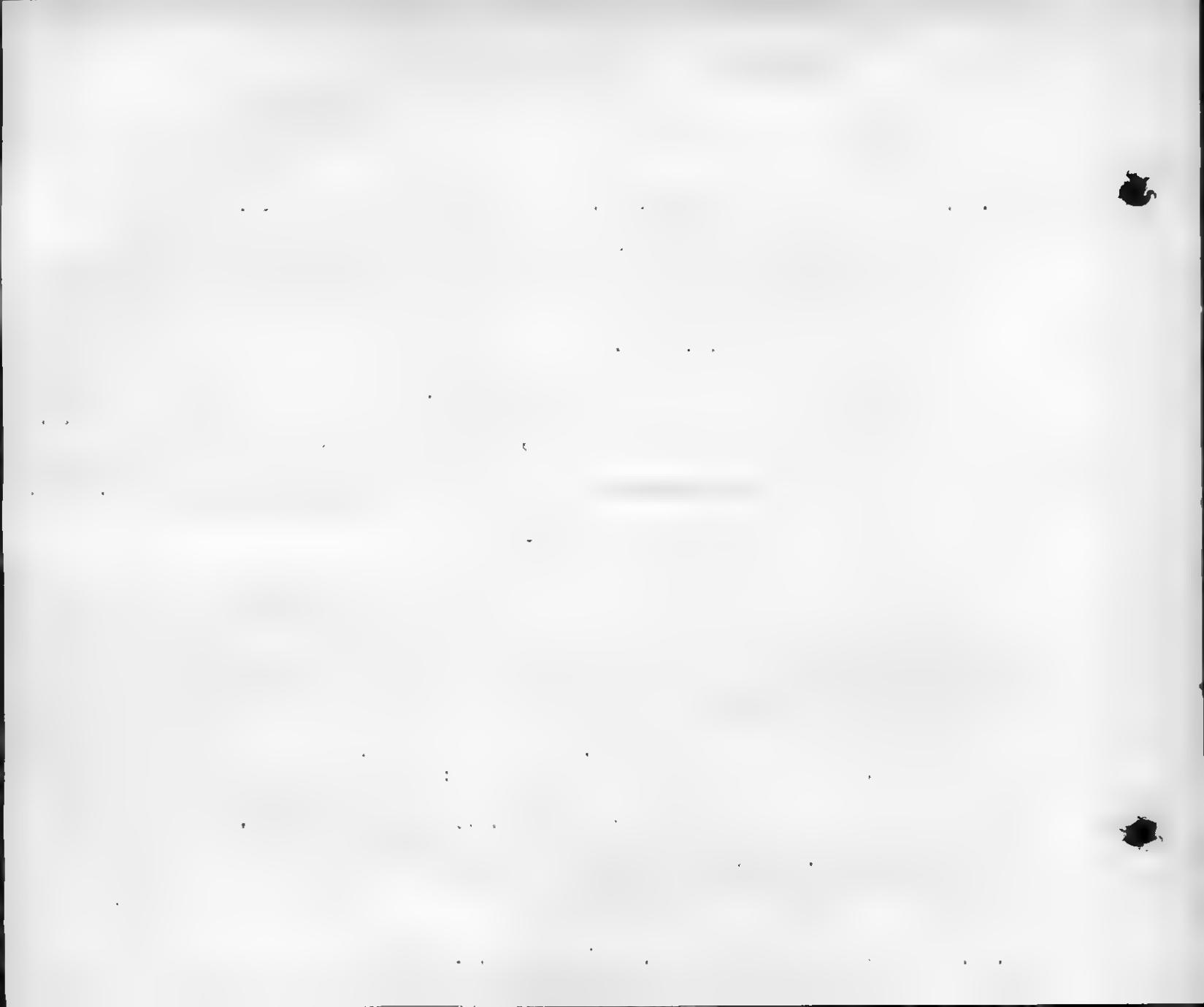
VS A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be given to the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10334			
CERTIFICATE OF DEATH										Reg. Dist. No. 215			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington								
d. LENGTH OF STAY IN 1b 26 days					e. STREET ADDRESS 1363 Euclid Street, N.W.								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST. TLTION U. S. Naval Hospital, Bethesda, Md.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Waymond	Middle Everett	Last HOLLAND	4. DATE OF DEATH September 26		Month September	Day 26	Year 1958				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-97		9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY U.S.Gov't.			11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY USA				
13. FATHER'S NAME William HOLLAND					14. MOTHER'S MAIDEN NAME Dora M. STORLITZ								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes			16. SOCIAL SECURITY NO. 577-09-9036			17. INFORMANT Wife, Gertrude Holland, 1306 Euclid St., NW			Address Washington, D.C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema										INTERVAL BETWEEN ONSET AND DEATH 1 mo. apr.			
162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Bronchogenic carcinoma										unknown			
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington, D.C.		(County) District of Columbia	(State) MD			
21. I certify that I attended the deceased from Sept. 1, 1958 , to Sept. 26, 1958 , that I last saw the deceased alive on Sept. 25, 1958 , and that death occurred at 6:40 AM , from the causes and on the date stated above										ADDRESS (Street, city or town, state) W. E. Jarvis, 1432 U Street, N.W., Washington, D.C.	DATE SIGNED 9-27-58		
ACTUAL SIGNATURE <i>Jerome A. Gold</i>										PHYSICIAN'S NAME (Type) Jerome A. Gold, LT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 10-3-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) Arlington	(State) Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Jarvis, 1432 U Street, N.W., Washington, D.C.</i>										24a. REC'D BY REGISTRAR SEP 30 '58	24b. REGISTRAR'S SIGNATURE <i>Cushing S. Kraus</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10281

CERTIFICATE OF DEATH

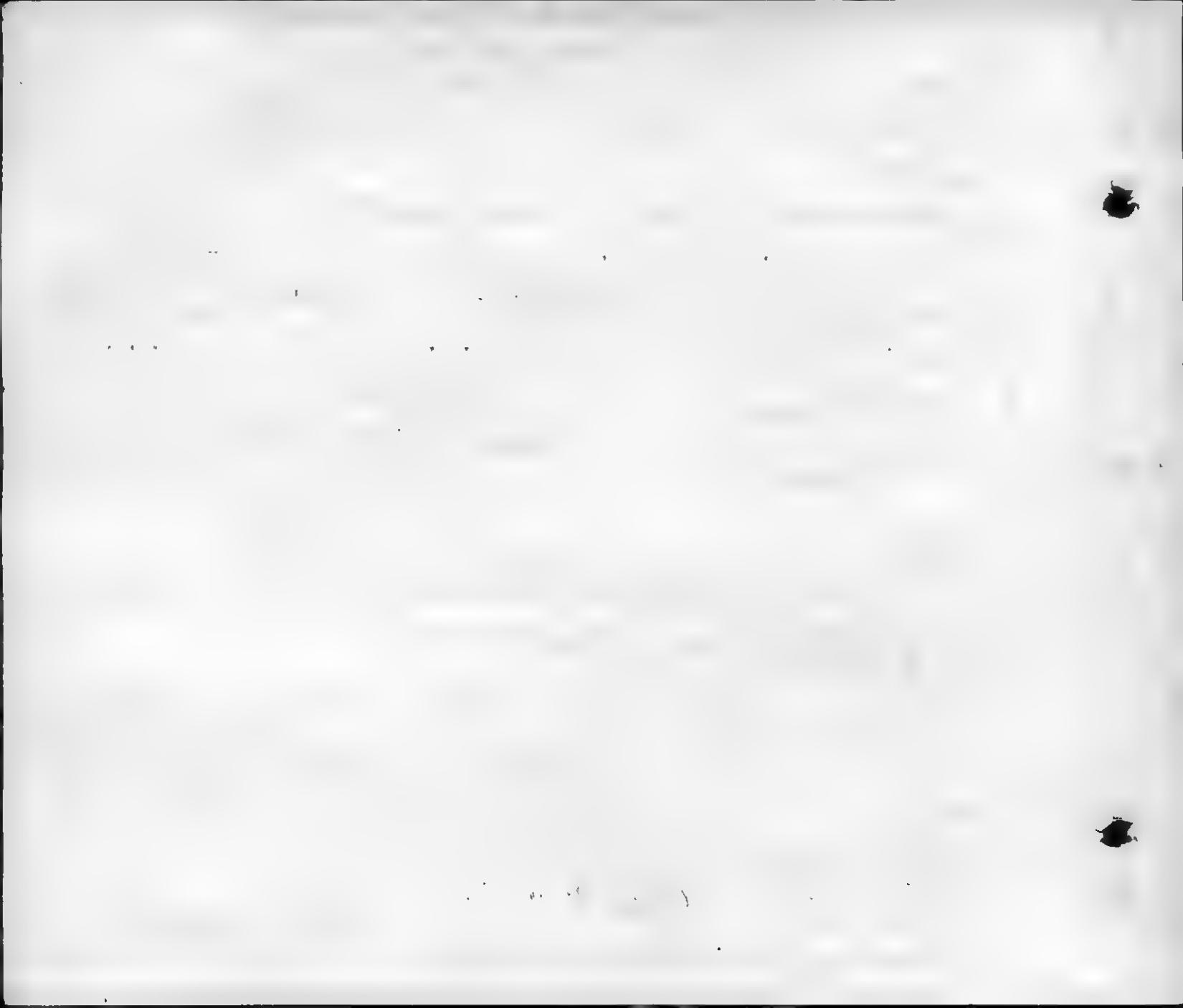
10335

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE Maryland		b. COUNTY T. P.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 67 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 16 Canary Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First L.	Middle A.	Last Horton	4. DATE OF DEATH 9 - 17 - 19 58	Month 9	Day - 17 -	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-'93	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Horton		14. MOTHER'S MAIDEN NAME Martha Duvall		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Washington Sanitarium & Hospital Records	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Left Cerebellar Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3-4 hours</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Left Subarachnoid hemorrhage 3-4 hours</p> <p>DUE TO (c) Alzamandibularis & Thromboflegmone 1/2 hour</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> <p>Left Hemithorax, Sputum Bacterial Endocarditis Diabetes</p>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 08-16-1958 , to Sept 17, 1958 , that I last saw the deceased alive on Sept. 16, 1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Russell B. Arnold				ADDRESS (Street, city or town, state) 8801 Colindale Road, Silver Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Society)		22b. DATE THEREOF Sept 19, 1958		22c. NAME OF CEMETERY OR CREMATORIUM National Memorial Park		22d. LOCATION (City, town, or county) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW DC		ADDRESS Arthur Walters, 254 Carroll St NW DC		24a. REC'D BY REGISTRAR DATE SEP 19 '58		24b. REGISTRAR'S SIGNATURE C. Anna S. Trahan	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10364

CERTIFICATE OF DEATH

Reg. Dist. No.

10336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 2963 Tilden Street, N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First William	Middle R	Last Houchen
4. DATE OF DEATH September 5 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 8, 1872
			9. AGE (In years lost birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kotikov		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Indiana	
12 CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME JOHN LEWIS HOUCHEN		14. MOTHER'S MAIDEN NAME AMANDA TANNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service) No		17. INFORMANT Mary Rose Houchen, 2963 Tilden St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO Cardiac sclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-25, 1958, to 9-5, 1958, that I last saw the deceased alive on 9-5, 1958, and that death occurred at 11:05 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) MD 5200 Lincoln Rd NW DATE SIGNED 8-6-58	
ACTUAL SIGNATURE Wm. Fleet Luckett			
PHYSICIAN'S NAME (Type) Wm. Fleet Luckett			
22a. BURIAL CREMATION, REMOVAL AND SPREADERS cremation		22b. DATE THEREOF 9/8/58	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town or county) Ft. Lincoln Crematory Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Morris Co.		ADDRESS 2901-14 1/2 ST. N.W. D.C.	
		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
		24b. REGISTRAR'S SIGNATURE John S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10365

CERTIFICATE OF DEATH

Reg. Dist. No.

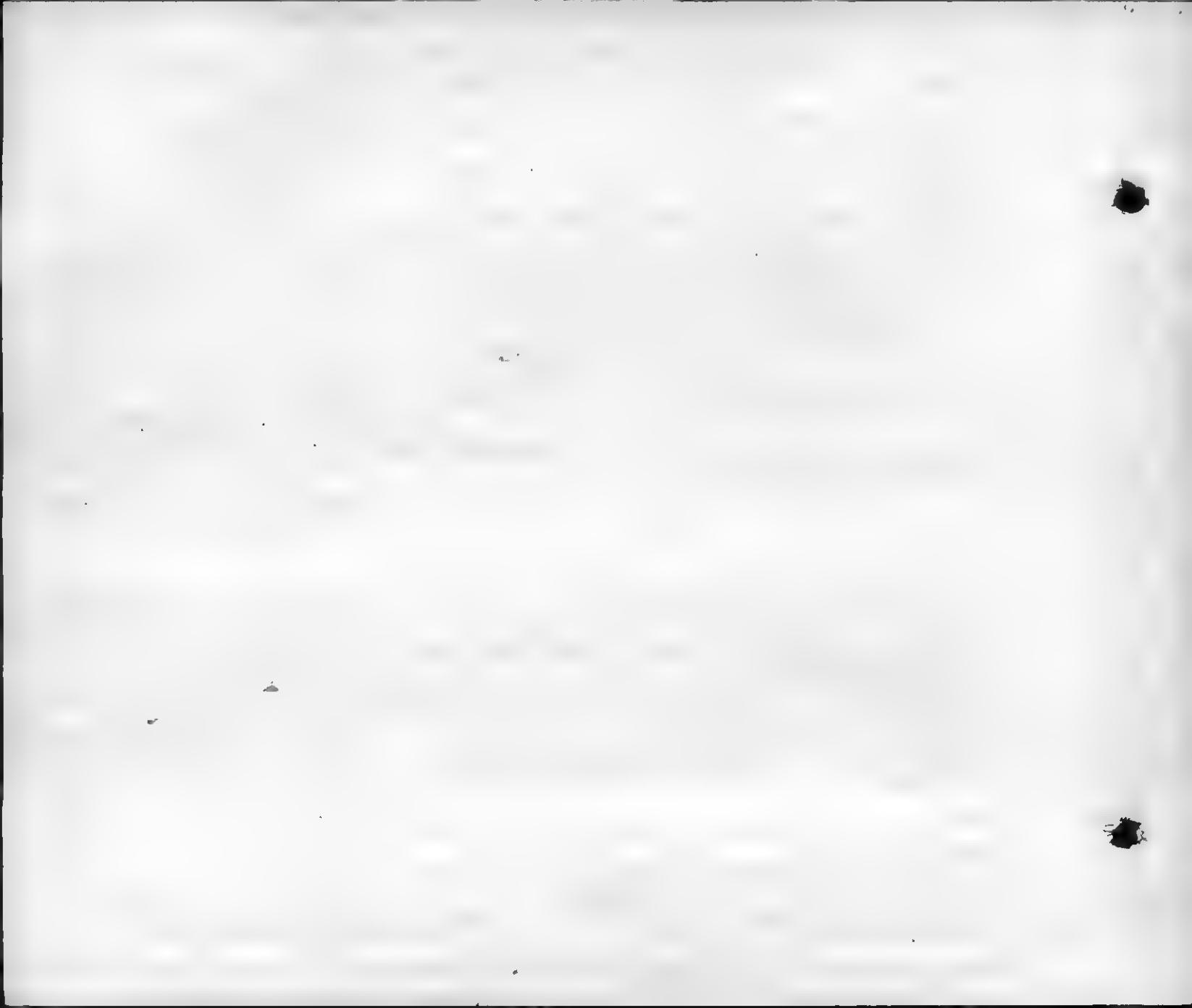
10337

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Diney Maryland		Colonial Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Brooke Grove Chronic Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mellie	Middle T.	Last Hoy
4. DATE OF DEATH	Month Sept-	Day 10	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26 1879
9. AGE (In years last birthday) 99 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Govt worker Silver Spr- Md + U.S.A.	
10c. FATHER'S NAME Patrick Ryan		11. BIRTHPLACE (State or foreign country) Mary Devaney	
12. CITIZEN OF WHAT COUNTRY/ Address 99 1/2 Red Langston Rd Bethesda Md.		13. MOTHER'S MAIDEN NAME	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		15. SOCIAL SECURITY NO.	
16. INFORMANT Mrs Donald Watson		17. DUE TO Lethal Hemorrhage	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592v DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) DUE TO Arterio Thrombosis - Thrombotic Neophritis		days	
(c) DUE TO Lethal Hemorrhage		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g., p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1956 to Sept 10, 1958, that I last saw the deceased alive on 7/11/1958, and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. J. W. Bird		ADDRESS (Street, city or town, state) M.D. Sandy Spring Md 9/10/58	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL* (Specify) Burial		22b. DATE THEREOF 9-12-58	
22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		22d. LOCATION (City, town, or county) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins 3821-14th St. N.W. Wash. D.C.		ADDRESS Dated SEP 15 '58	
		24a. REC'D BY REGISTRAR S. J. Collins	
		24b. REGISTRAR'S SIGNATURE Arthur & Francis C. J. Collins	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar for its burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar for its burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10338

10282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Town of Park</i>		c. LENGTH OF STAY IN 1b <i>708 Philo Ave</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>807-10 st. N.E.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>708 Philo Ave Nursing Home</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Emi</i>	Middle <i>B.</i>	Last <i>HUGHES</i>	4. DATE OF DEATH <i>OCT. 20, 1882</i>	Month <i>SEPT.</i>	Day <i>6</i>	Year <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 20, 1882</i>		9. AGE (In years Leave children yrs <i>73</i>)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>yo 41</i>		
13. FATHER'S NAME <i>Archibald BURGESS</i>		14. MOTHER'S MAIDEN NAME <i>SARAH A. TURPIN</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		Address <i>Mrs. Kay Brad Catherine & Franks - Lexington NC</i>		
16. SOCIAL SECURITY NO		17. INFORMANT <i>Catherine & Franks - Lexington NC</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO <i>Gastric Decomposition</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Hy pernicious</i>		(c)				8.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Chest</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above						ADDRESS (Street, city or town, state) <i>William Blvd</i>		
ACTUAL SIGNATURE <i>William Blvd</i>		M.D. <i>9076 W. George Rd</i>		DATE SIGNED <i>Sept 1, 1958</i>				
PHYSICIAN'S NAME (Type) <i>William Blvd</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-9-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Congressional</i>		22d. LOCATION (City, town, or county) <i>Washington DC</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Leesens</i>		ADDRESS <i>Wash. D.C.</i>		24a. REC'D BY REGISTRAR SEP 8 1958 DATE		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Traud</i>		

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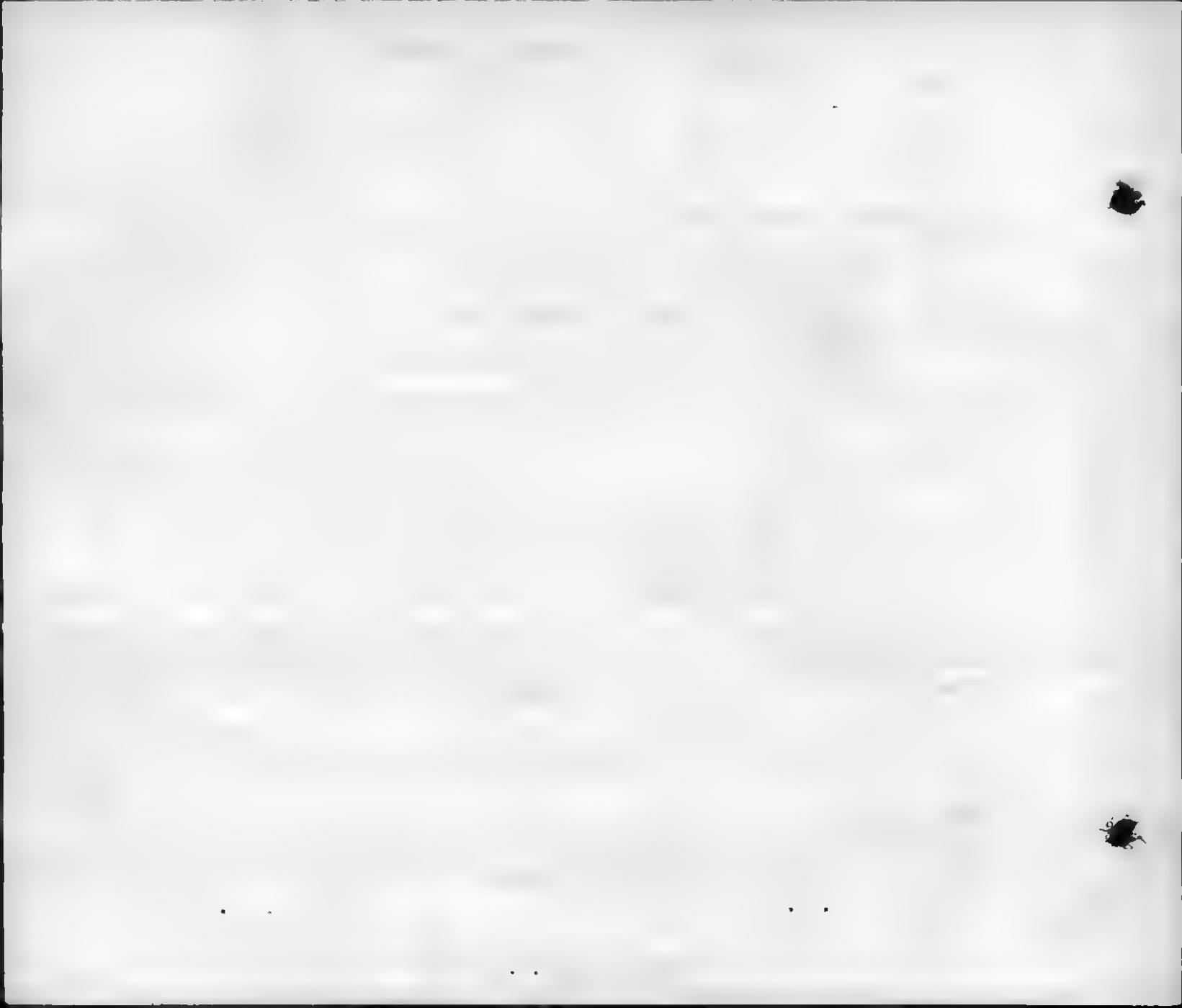
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10366

CERTIFICATE OF DEATH

Reg. Dist. No. 10339

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>T.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rehoboth</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>The Burbank</i>		d. STREET ADDRESS <i>1918-18th. St. N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Jessie</i>	Middle <i>Hughes</i>	Last Month Day Year <i>Sept. 8 1958</i>
4. SEX <i>Female colored</i>	5. COLOR OR RACE <i>Caucasian</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Feb. 22, 1890</i>
8. AGE (In years from birthdate) <i>68 yrs.</i>	9. IF UNDER 1 YEAR Months <i>0</i>	10. IF UNDER 24 HRS Days <i>0</i>	11. Hours <i>0</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Andrew Hughes</i>	14. MOTHER'S MAIDEN NAME <i>Lottie Bealer</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anger from Heart Failure</i> <i>Anoxia from Heart Failure</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <i>9/7 1958</i> , and that death occurred at <i>6:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Alvin E. Kay</i>	M.D.	ADDRESS (Street, city or town, state) <i>1835 Eye St. N.W. Washington, D.C.</i>	DATE SIGNED <i>9/8/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9.10.58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>1890-9</i>	22d. LOCATION (City, town, or county) <i>Lexington, Va.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>No. 10366</i>	ADDRESS <i>1890-9</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

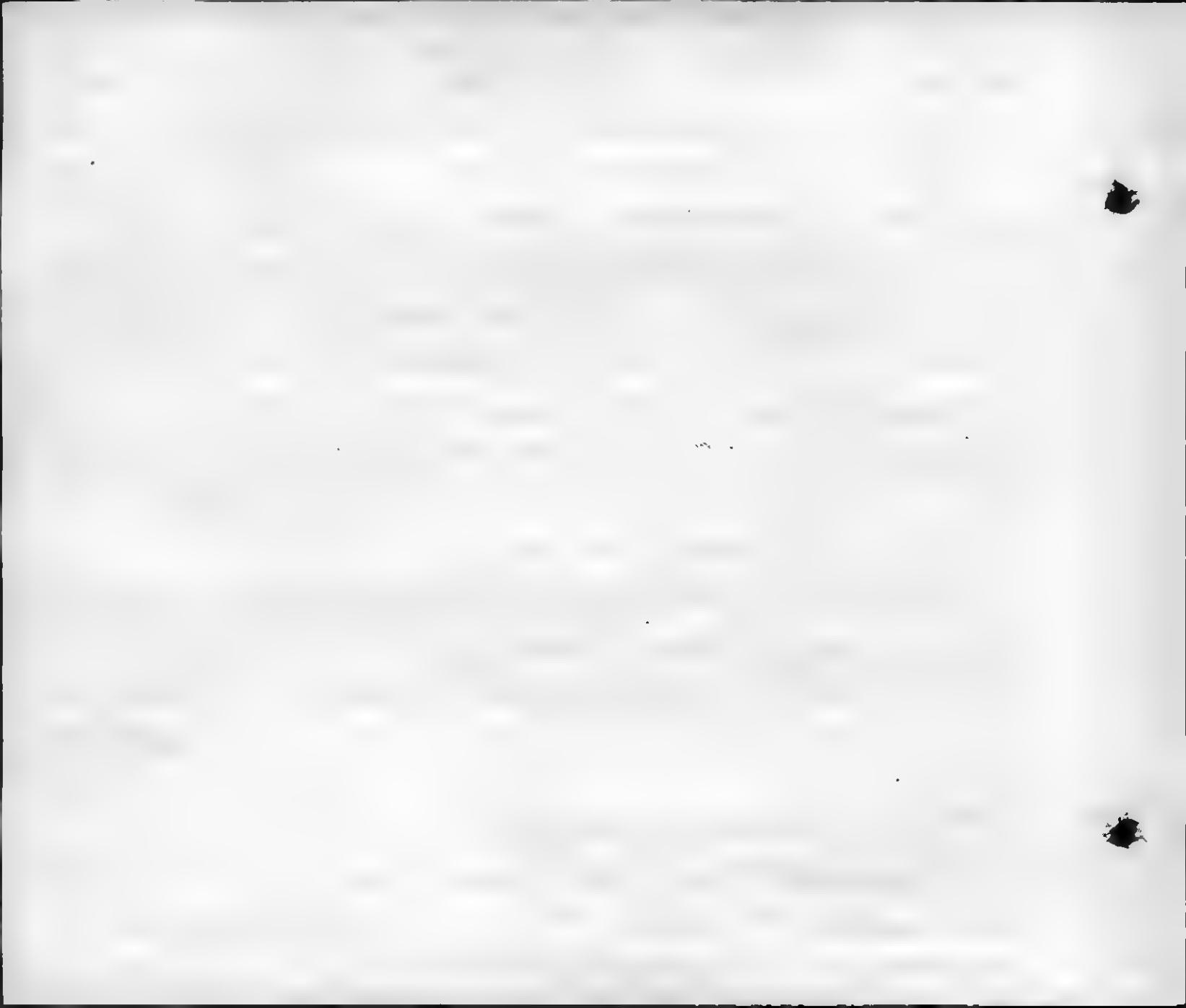
10367

CERTIFICATE OF DEATH

10340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barnsville</i>	
c. LENGTH OF STAY IN 1b <i>15 days</i>		d. STREET ADDRESS <i>51. Mary's Rectory</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John William Hyland</i>		First	Middle
4. DATE OF DEATH <i>Sept. 7 1958</i>		Month	Day
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 30 1888</i>		9. AGE (In years lost birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 months 0 days 0 hours 0 min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Casher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md. Racing Assoc.</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Martin W. Hyland</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Burns</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-07-9458</i>	
17. INFORMANT <i>Martin W. Hyland, Barnsville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b) Osteosclerotic heart disease</i>		1-month.	
DUE TO (c) <i>Bronchopneumonia</i>		3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>491X</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> 19 p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i>Dawsonville</i> (County) <i></i> (State) <i></i>	
21. I certify that I attended the deceased from <i>July 11, 1958</i> to <i>Sept 7, 1958</i> , that I last saw the deceased alive on <i>Sept 7, 1958</i> , and that death occurred at <i>9:24 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Dawsonville</i> DATE SIGNED <i>7 Sept. 58</i>			
ACTUAL SIGNATURE <i>John G. Fawcett</i>		PHYSICIAN'S NAME (Type) <i>John G. Fawcett</i> P.O. Box 40, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>8/10/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Fate & Hansen</i>		22d. LOCATION (City, town, or county) <i>Gaines Silver Spring, Md.</i> (State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wellman, B. Wilson, Barnsville, Md.</i>		24a. REC'D BY REGISTRAR DATE SEP 11 '58	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10341

10368

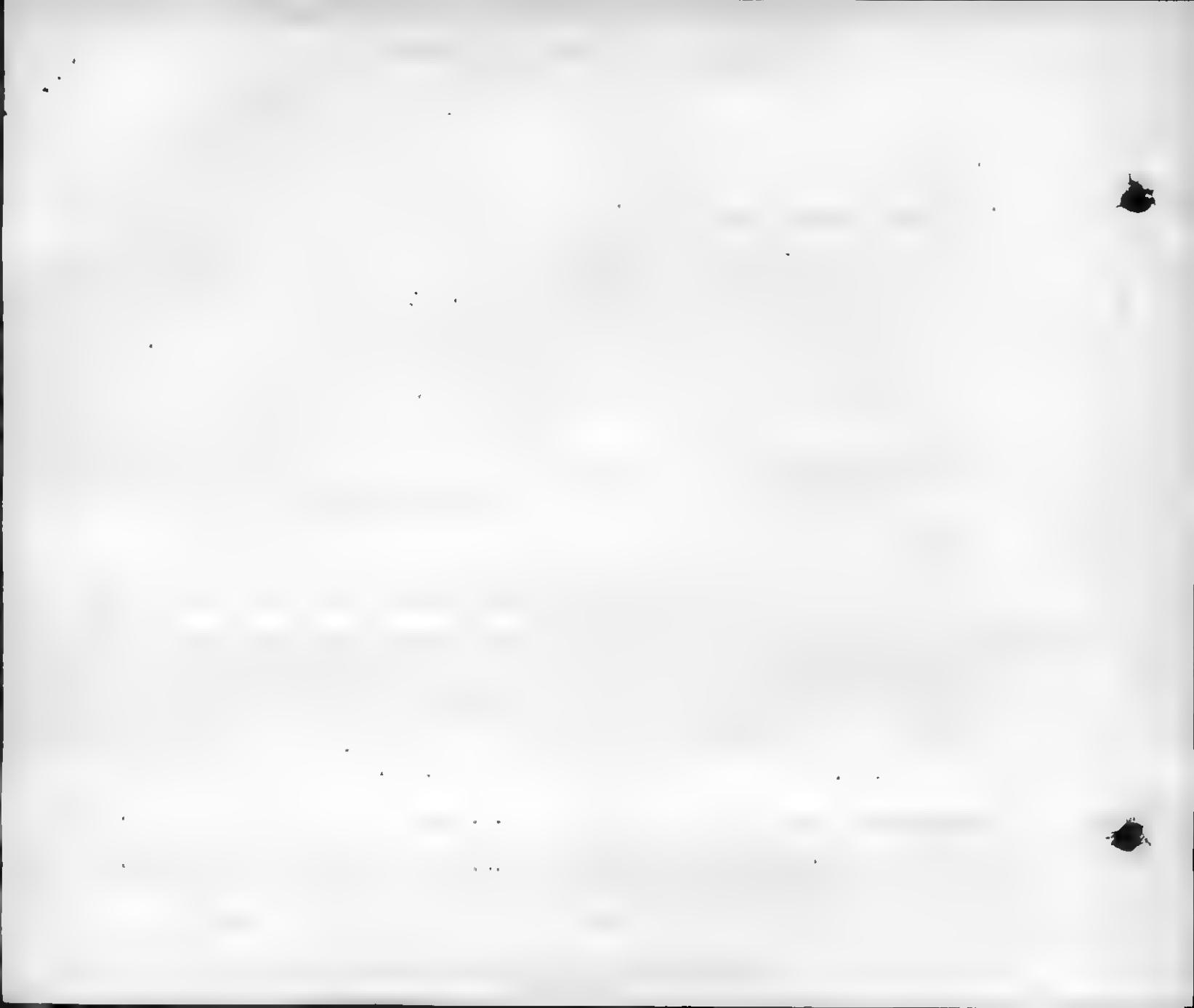
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 340 Midway Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Gregory		First	Middle Paul	Last Johnson	4. DATE OF DEATH September 5 1958	Month September	Day 5	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3 Sept. 1958	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Herbert JOHNSON		14. MOTHER'S MAIDEN NAME Frances D. DRAKE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Herbert Johnson (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7/13.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Hyaline-necrotic disease				INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3 Sept. 1958, to 5 Sept. 1958, that I last saw the deceased alive on 5 Sept. 1958, and that death occurred at 3:15 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. 9-5-58		
ACTUAL SIGNATURE Howard A. Pearson						DATE SIGNED 9-5-58		
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-58		22c. NAME OF CEMETERY OR CREMATORIUM Holy Face Cemetery		22d. LOCATION (City, town, or county) Leonardtown, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home, Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 9 '58		24b. REGISTRAR'S SIGNATURE Albert J. Lewis		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

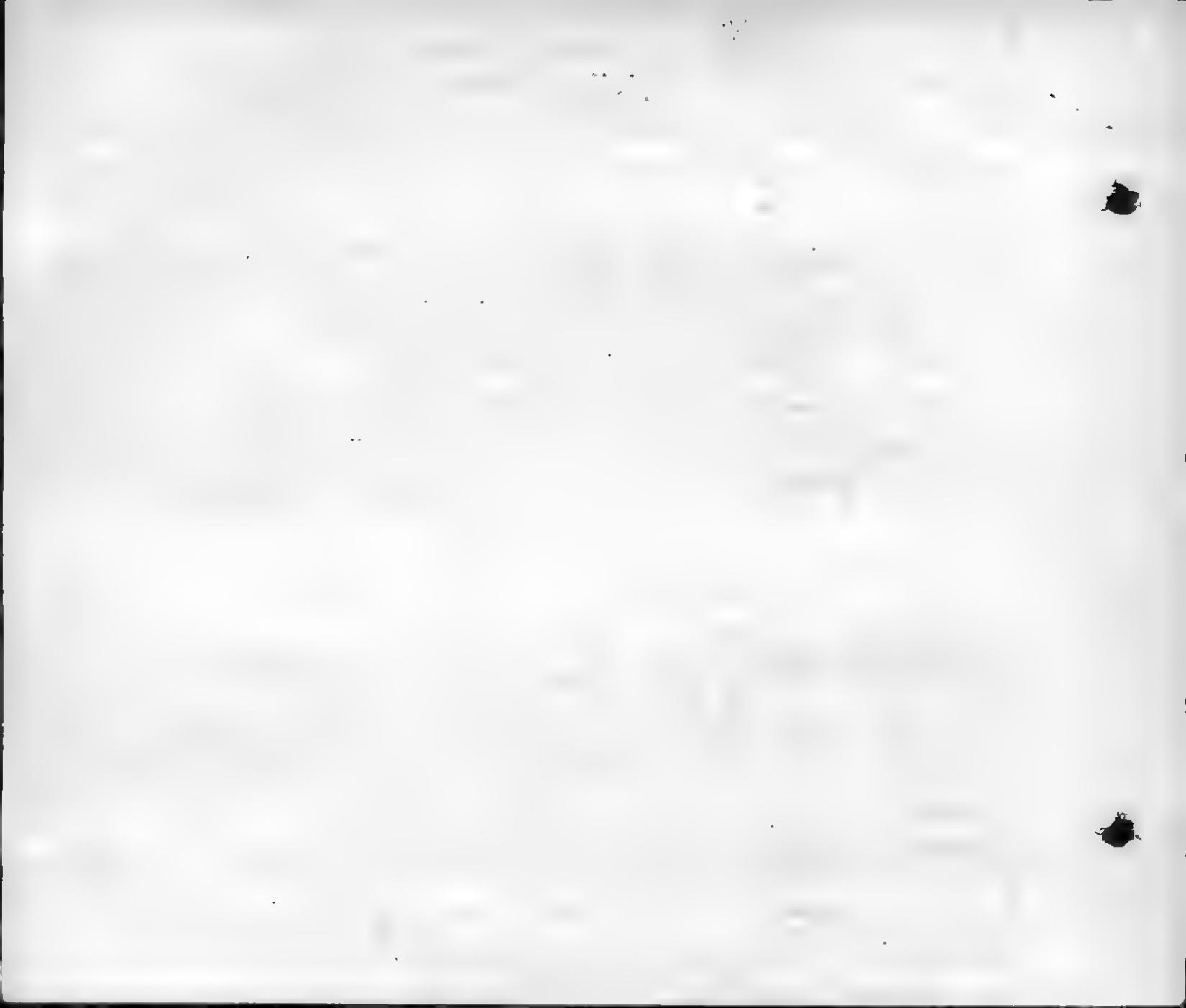
10342

10369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3517 Randolph Road		d. STREET ADDRESS 3517 Randolph Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CHARLIE		First	Middle	Lost	4. DATE OF DEATH Sept. 27	Month	Day	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 21, 1871	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles J. Jones			14. MOTHER'S MAIDEN NAME Mary E Trunnell			Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Carroll V Jones-son-same as 2d				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacteremia</u> INTERVAL BETWEEN ONSET AND DEATH 2 weeks - 602 X DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Retro Renal Alveosis - Pylonephritis</u> 2 years (c) <u>Bilateral Stellate Renal Calculi</u> 15 years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct 27, 1958</u> to <u>27 Sept 1958</u> that I last saw the deceased alive on <u>27 Sept 1958</u> , and that death occurred at <u>1156 AM</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>W.H. Murphy</u> ADDRESS (Street, city or town/state) <u>6151 Montg. Ave., Rockville, Md.</u> DATE SIGNED <u>28 Sept 1958</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Umhrey</u> <u>XXXXXX</u>		ADDRESS Bethesda, Maryland		24a. REC'D. REGISTRAR SEP 30 1958		24b. REGISTRAR'S SIGNATURE <u>Carroll V. Jones</u>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10343

10283

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>DOA.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park 17</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>7711 Greenwood Ave.</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Amelia</i>	Middle <i>Anna</i>	Last <i>Kidd</i>	4. DATE OF DEATH <i>Sept. 28</i>	Month <i>Sept.</i>	Day <i>28</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>wh</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-14-90</i>	9. AGE (in years last birthday) <i>68 yrs.</i>	IF UNDER 1 YEAR <i>Months</i>	IF UNDER 24 HRS. <i>Days</i>	Hours <i>Hours</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>kitchen helper-</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William H. Hood.</i>		14. MOTHER'S MAIDEN NAME <i>Emma Hunt Hood</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Arteriosclerosis, generalized</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Two minutes</i>			
				Known <i>1 year</i>			
				Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>			
21. I certify that I attended the deceased from <i>October</i> , 1957, to <i>September 28, 1958</i> , that I last saw the deceased alive on <i>September 28, 1958</i> , and that death occurred at <i>2:40 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>8837 Gloryn Ave. Belvoir Spring Rd.</i>		DATE SIGNED <i>Sept 29 1958</i>	
ACTUAL SIGNATURE <i>Aaron H. Traum</i>		M.D. <i>8837 Gloryn Ave Belvoir Spring Rd Sept 29 1958</i>					
PHYSICIAN'S NAME (Type) <i>AARON H. TRAUM</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 3, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>LINWOOD CEMETERY</i>		22d. LOCATION (City, town, or county) <i>BAILEY BLAINE, OHIO</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John D. Walker</i>		ADDRESS <i>254 Carroll St NW, D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 1 '58</i>		24b. REGISTRAR'S SIGNATURE <i>J. G. Traum</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 1/2 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

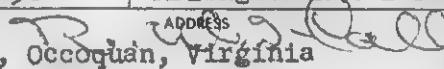
10370

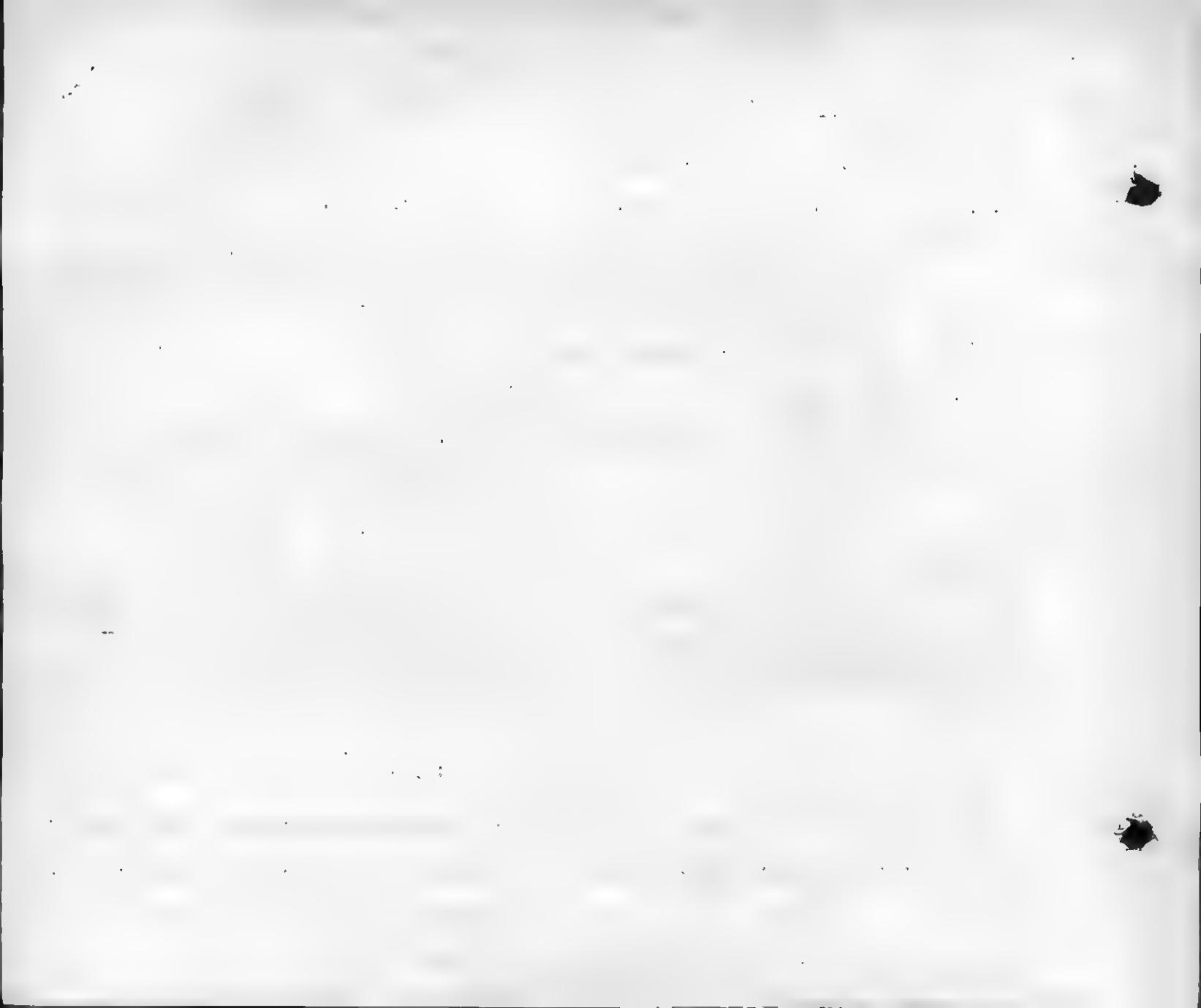
CERTIFICATE OF DEATH

10344
25

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE VIRGINIA		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 20 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 312 3rd Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Russell	Last KINSMAN	4. DATE OF DEATH Sept. 8 1958	Month Sept.	Day 8	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 27 February 1895	9. AGE (In years last birthday) 63 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Henry KINSMAN				14. MOTHER'S MAIDEN NAME Greta ISACSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I&II 225 20 8043		17. INFORMANT (Wife) Mrs. Amie Harper KINSMAN (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, CEREBRAL VESSELS, MULTIPLE 2 WEEKS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ARTERIOSCLEROSIS OF CEREBRAL VESSELS ? YEARS DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSION SEVERE ESSENTIAL							
19. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) U.S. Naval Hospital, NNMC, Bethesda, Md.	(County)	(State)	
21. I certify that I attended the deceased from 19 August 1958 , to 8 Sept. 1958 , that I last saw the deceased alive on 8 Sept. 1958 , and that death occurred at 7:45A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMC, Bethesda, Md.							
DATE SIGNED 10-10-58							
ACTUAL SIGNATURE 							
PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN							
U.S. Naval Hospital, Bethesda, Md. 9-8-58							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-11-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) Arlington, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Occoquan, Virginia	24a. REC'D BY REGISTRAR 10 '58	24b. REGISTRAR'S SIGNATURE Orpha S. King			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10371 CERTIFICATE OF DEATH

Reg. Dist. No. 215
10345

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 5 mos. 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3100 Connecticut Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle (mmn) KLAUS	Last KLAUS	4. DATE OF DEATH September 13 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 27 November 1892	9. AGE (in years from birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME William John KLAUS		14. MOTHER'S MAIDEN NAME (First Name Unknown) HAGER		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, give name or date of service) Yes WW-I&II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Arda P. KLAUS (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 100X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA OF LUNGS DUE TO (c) SQUAMOUS CELL CARCINOMA ESOPHAGUS		48 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April 1958 to 13 Sept. 1958 , that I last saw the deceased alive on 13 September 1958 , and that death occurred at 4:00A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>George W. Taylor Jr.</i> M.D. U.S. Naval Hospital, Bethesda, Md. 9-13-58					
ADDRESS (Street, city or town, state) DATE SIGNED					
PHYSICIAN'S NAME (Type) George W. Taylor, Jr. CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-17-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) Arlington, Virginia	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. J. Thompson</i>		ADDRESS 557 Wisconsin Ave. Bethesda, Md.	24a. REC'D BY REGISTRAR DATE SEP 16 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Woods, Rockville		d. STREET ADDRESS 13004 Parklnd Drive		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Fred	Middle Edward	Last Kotz	4. DATE OF DEATH	Month Sept.	Day 4	Year 1958
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1906	9. AGE (In years at birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 MONTHS Days 0	12. IF UNDER 24 HOURS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxicab Owner-Operator		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME James Edward Kotz		14. MOTHER'S MAIDEN NAME Elizabeth Miley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		
17. INFORMANT Mrs. Regina Kotz		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 40.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Address 13004 Parkland Drive Wheaton Woods, Md.		
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20d. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20e. TIME OF INJURY Hour a. m. p. m.		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20h. (City or Town) (County) (State)		
20i. (City or Town) (County) (State)		19. DATE OF DEATH 9-8-58		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE Frank J. Bloschart		
EXAMINER'S NAME (Type) FRANK J. Bloschart		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		24. DATE REMOVED 9-8-58		25. DATE RECEIVED BY REGISTRAR SEP 8 '58		
26. BURIAL, CREMATON, REMOVAL (Specify) Burial		27. NAME OF CEMETERY OR CREMATORIUM Wardensville		28. LOCATION (City, town, or county) West Virginia.		29. REGISTRAR'S SIGNATURE John J. Lee Son Wash. D. C.		
30. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee Son		31. ADDRESS Wash. D. C.		32. DATE SEP 8 '58		33. CLOSING PARENTHESIS		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
35 11-1345 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18 Film 235 1

Reg. Dist. No 1347

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PHM3. Page 5 may be retained by you or your agent.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived - If institution Res'd before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb DCA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sandarium and Hospital		d. STREET ADDRESS 207 Spring Ave	
3. NAME OF DECEASED (Type or print) Vincent James Lanza Jr.		4. DATE OF DEATH Month Day Year Sept 18 1958	
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-12-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY? None	
13. FATHER'S NAME Vincent James Lanza Jr.		14. MOTHER'S MAIDEN NAME Petricia Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOC(A) SECURITY NO. -	
17. INFORMANT Hospital Records - 7600 Carroll Ave Tak.Pk.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Interstitial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) 525X DUE TO cause lost. (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Hour 19	Month, Day, Year a.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broadhead	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-18-58
EXAMINER'S NAME (Type) FRANK J. BROADHEAD			
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 22, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery	22d. LOCATION (City, town, or county) Arlington
23. FUNERAL DIRECTOR'S SIGNATURE Katherine Walters	ADDRESS 254 Carroll St N.W. DC	24a. REC'D. BY REGISTRAR SEP 22 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10285

CERTIFICATE OF DEATH

Reg. Dist. No.

10348

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>Washington San. & Hosp.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>		d. STREET ADDRESS <u>710 Wabash Ave</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>710 Wabash Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Jennie</u>		First	Middle	Last	4. DATE OF DEATH <u>9/ 26</u>	Month	Day	Year
5. SEX <u>f</u>		6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12-13-77</u>	9. AGE (in years from birthdate) <u>80 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Scott Woodring</u>		14. MOTHER'S MAIDEN NAME <u>Nancy McMullen</u>				Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>old hosp. record</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Hypertension</u> DUE TO (c)						30 yrs.		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.)		(County) (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D. <u>Takoma Park</u> DATE SIGNED <u>9/26/58</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Sept 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>GEORGE WASHINGTON Cemetery</u>		22d. LOCATION (City, town, or county) <u>Riach St., Hyattsville, Prince George's Co., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare</u>		ADDRESS <u>254 Carroll St. N.W., D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 1958</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Evans</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10373

CERTIFICATE OF DEATH

Reg. Dist. No.

10349

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Montgomery</i>		a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Olney</i>		<i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Brooke Grove Foundation</i>		<i>1003 Paul Drive</i>	
e. LENGTH OF STAY IN lb		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11 days			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Cora Jane Learmonth</i>		<i>Learmonth</i>	<i>Jane</i>
4. DATE OF DEATH		Month	Day Year
<i>Sept. 21 1958</i>		<i>Sept.</i>	<i>21</i> <i>1958</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>Female</i>		<i>Cauc.</i>	<i>WIDOWED <input checked="" type="checkbox"/></i> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	
<i>Feb. 9 1882</i>		<i>16 yr.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Promemaker</i>		<i>Own home</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Iowa</i>		<i>U.S.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Robert McClure</i>		<i>Nora Mead</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>none</i>	
17. INFORMANT		Address <i>Rocky Hill Rd</i>	
<i>Robert Learmonth 1003 Paul Dr</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>12 hours</i>	
<i>260x</i>		<i>CEFRB22A. THROMBOSIS</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		<i>2 years</i>	
(b) <i>DIABETES MELLITUS</i>			
DUE TO (c) <i>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</i>		<i>20 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>RHEUMATOID ARTHRITIS</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> , 19 <i>30</i> to <i>21 Sept.</i> 19 <i>58</i> , that I last saw the deceased alive on <i>19 Sept. 1958</i> , and that death occurred at <i>9446 1/2 M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Gordon Rosenberger</i> M.D. <i>26 N. St. 11th & DYE</i> DATE SIGNED <i>21 Sept. 1958</i>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <i>GORDON ROSENBERGER</i>			
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>TU. 9/26/58</i>		22b. DATE THEREOF	
		22c. NAME OF CEMETERY OR CREMATORIUM <i>PELU CITY CEMETRY</i>	
		22d. LOCATION (City, town, or county) <i>PELU, ILLINOIS</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska,</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
		24a. REC'D BY REGISTRAR DATE <i>SEP 23 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Carla S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10350

CERTIFICATE OF DEATH

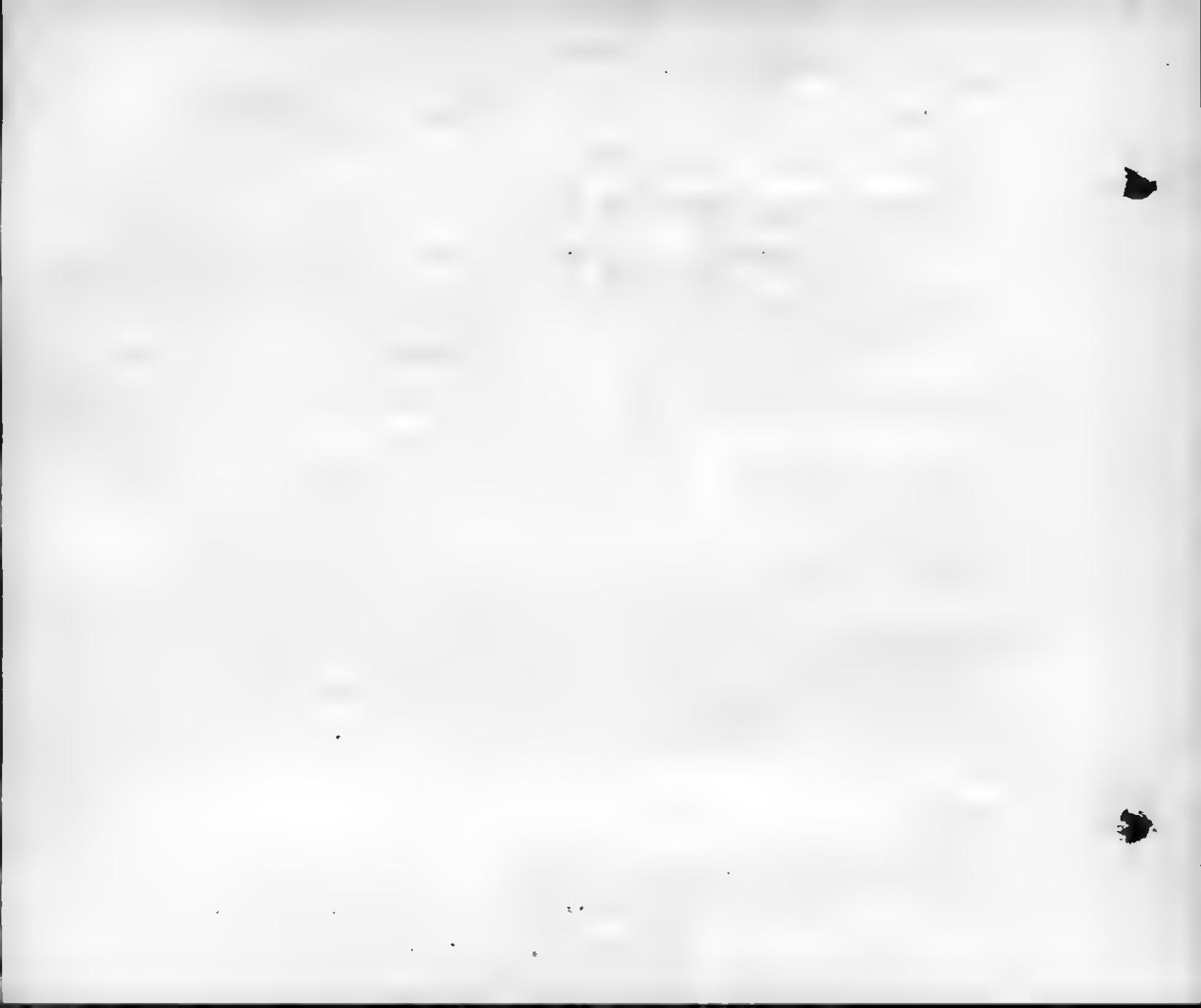
Reg. Dist. No.

10374

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 31 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mildred		First	Middle	Last	4. DATE OF DEATH Lee	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/08		9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME John Lee		14. MOTHER'S MAIDEN NAME Allie Walker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records		Address Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO Pelvic Abscess (c) DUE TO Pyosalpinx. Ruptured urinary Bladder (c) Bronchopneumonia. } INTERVAL BETWEEN ONSET AND DEATH 6 months 2 days hours									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Ascaris									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Olney		(County) Maryland	(State) Md.
21. I certify that I attended the deceased from Sept 21, 1958 , to Sept 23, 1958 , that I last saw the deceased alive on Sept 23, 1958 , and that death occurred at 9:25 AM , from the causes and on the date stated above									
ACTUAL SIGNATURE Richard A. Yates M.D. ADDRESS (Street, city or town, state) Olney, Maryland DATE SIGNED 9-24-58									
22a. BURIAL, CREMATION, REMOVAL (specify) BURIAL		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORIUM Oak Grove,		22d. LOCATION (City, town, or county) Mt. Zion, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10286

CERTIFICATE OF DEATH

10351

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash Sanitarium</i>		e. STREET ADDRESS <i>12807-Harris St Sspx</i>	
3. NAME OF DECEASED (Type or print) MINNIE		4. DATE OF DEATH LEOPOLD Sept 20 1958	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-29-1888	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House duties</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Russia</i>	
10c. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SOLOMON BERGER		14. MOTHER'S MAIDEN NAME ESTHER BERGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO.	
17. INFORMANT MELVIN ROMANOFF		Address 2807-HARRIS St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Leukemia</i>		INTERVAL BETWEEN ONSET AND DEATH 3 YRS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1955</i> to <i>Sept 20 1958</i> , that I last saw the deceased alive on <i>Sept 19 1958</i> , and that death occurred at <i>17th St</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 106 Longfellow St NW, Sept 29 1958	
ACTUAL SIGNATURE <i>Simon C. Weiner MD</i>		DATE SIGNED Sept 29 1958	
PHYSICIAN'S NAME (Type) Simon C. Weiner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-1958	
22c. NAME OF CEMETERY OR CREMATORIAL Marshall Belie Soc.		22d. LOCATION (City, town, or county) (State) NEW HAVEN CONN.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Wash. DC</i>		24a. REC'D BY REGISTRAR SEP 22 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18352

10325 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2212 Ross Rd SILVER SPRING, Md.		e. STREET ADDRESS 2212 Ross Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rose	Middle	Last Levine	4. DATE OF DEATH	Month Sept.	Day 15	Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21 1902	9. AGE (in years lost birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zalman Murnik		14. MOTHER'S MAIDEN NAME Chaya - - -					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Sidney Levine 2203 Mark Court, Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		CORONARY OCCLUSION				INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
CORONARY ARTERIO-SCLEROSIS						6 weeks	
19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from the causes and on the date stated above. ACTUAL DATE LeRoy Robins, M.D.		ADDRESS (Street, city or town) state 2480-16th NW 915-58					
PHYSICIAN'S NAME (Type) LeRoy Robins, M.D.		DATE SIGNED 2480 16th St., N.W.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 17, 1958		22c. NAME OF CEMETERY OR CREMATORIAL ELESAVETGRAD CEM.		22d. LOCATION (City, town, or county) WASHINGTON DC	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		ADDRESS 3501 14th St., NW.		24a. REC'D BY REGISTRAR DATE SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arnold S. Mandel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10376

CERTIFICATE OF DEATH

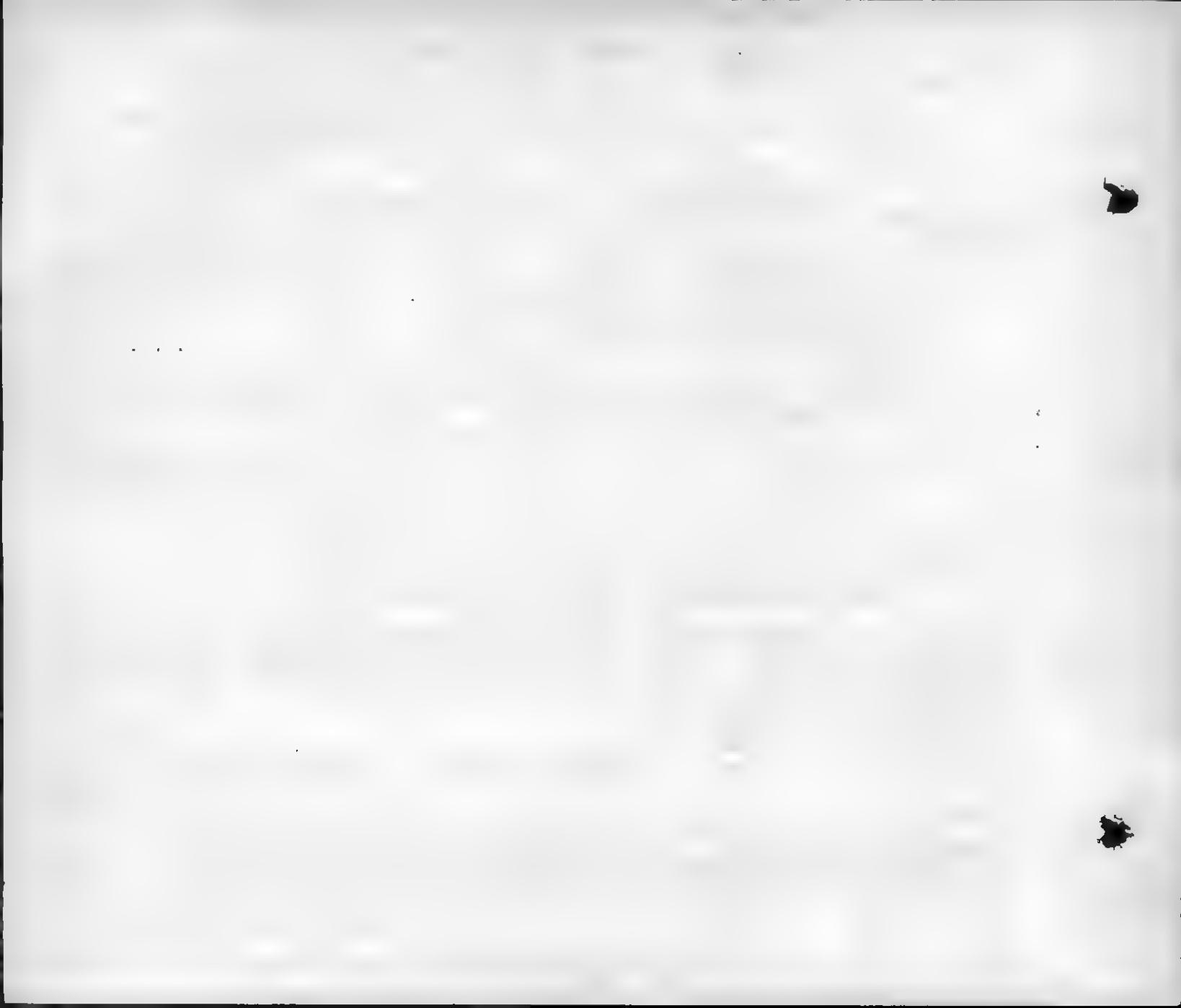
Reg. Dist. No.

10353

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2½ days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
3. NAME OF DECEASED (Type or print) Jerome		First J	Middle Lightfoot
4. DATE OF DEATH September 1 1958	Month September	Day 1	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1878
		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0
		11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Wash. D. C.	
10c. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BIRTHPLACE (State or foreign country) Wash. D. C.	
13. FATHER'S NAME John Jerome Leggibat		14. MOTHER'S MAIDEN NAME Lucy Whelby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 70	
17. INFORMANT Hospital Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and tracheobronchitis DUE TO 91X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Influenza		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) M.D. 4630 Larchmont Avenue, Bethesda, Md.	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) SUITLAND	
(County) Md.		(State) Md.	
21. I certify that I attended the deceased from August 28, 1958 to September 1, 1958 , that I last saw the deceased alive on August 31, 1958 , and that death occurred at 1:00 A.M. from the causes and on the date stated above. Robert N. Poole		ADDRESS (Street, city or town, state) 4630 Larchmont Avenue, Bethesda, Md.	
ACTUAL SIGNATURE Robert N. Poole		DATE SIGNED 9/1/58	
PHYSICIAN'S NAME (Type) ROBERT N. COHLE			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 9/13/58	
22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL HILL CEM.		22d. LOCATION (City, town, or county) SUITLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gluckin Sons 1756 Larchmont Ave		ADDRESS 1756 Larchmont Ave	
		24a. REC'D BY REGISTRAR DATE SEP 4 1958	
		24b. REGISTRAR'S SIGNATURE Conrad S. Poole	

X
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers Page 1 and
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

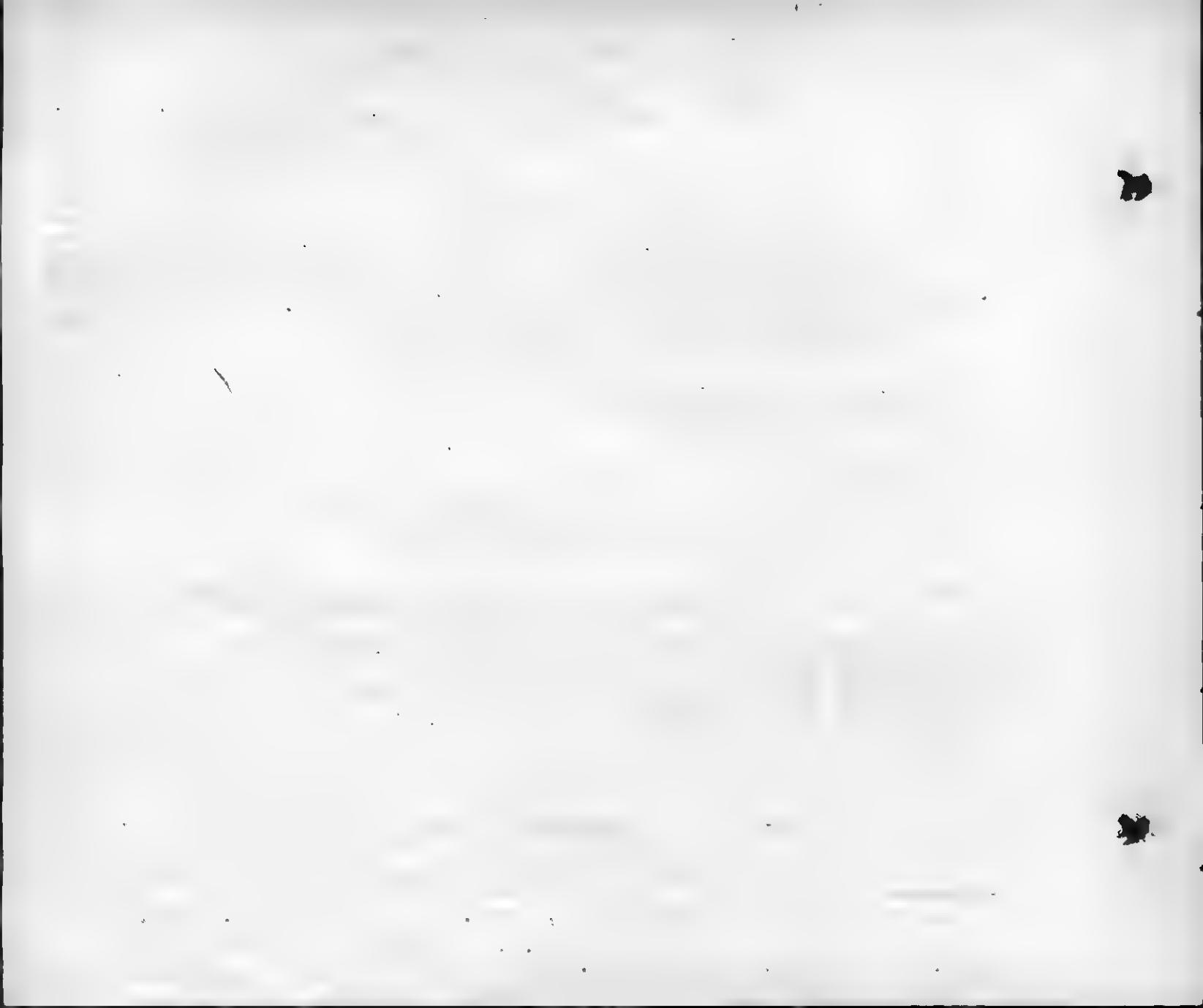
10287

CERTIFICATE OF DEATH

10354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>Takoma Park</i>		<i>Montgomery</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>6 yrs</i>		<i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>8502 Flower Ave.</i>		<i>18502 Flower Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
		<i>Mamie</i>	<i>Florence</i>
		Last	
		<i>Lilly</i>	
4. DATE OF DEATH		Month	Day
		<i>September</i>	<i>2</i>
		Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>Female</i>		<i>Caucasian</i>	<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years last birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS
<i>Nov. 14, 1866</i>		<i>91</i>	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>—</i>		<i>—</i>	<i>Tenn.</i>
12. CITIZEN OF WHAT COUNTRY			
		<i>U.S.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>James A. Moore</i>		<i>Mitchell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
(If yes, give war or dates of service)		<i>—</i>	<i>Morgan C. Smith, 8522 Flower Ave.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Uremia</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		14 days	
DUE TO DUE TO DUE TO		<i>Arterio sclerosis</i>	
(c)		yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
<i>19</i>		<i>Sept 1, 1958</i>	<i>Whiteville, Tenn.</i>
21. I certify that I attended the deceased from		22. DATE THEREOF	
<i>Aug 22, 1958, to Sept 2, 1958</i>		<i>9/3/58</i>	
alive on		and that death occurred at	
<i>Sept 1, 1958</i>		<i>1A M.</i>	
and that death occurred at		ADDRESS (Street, city or town, state)	
<i>Charles W. Humphrey, Jr.</i>		<i>1746 K St. Wash, DC.</i>	
ACTUAL SIGNATURE		DATE SIGNED	
<i>Charles W. Humphrey, Jr.</i>		<i>9/4/58</i>	
22a. BURIAL CEREMONY REMOVAL (Specify removal)		22c. NAME OF CEMETERY OR CREMATORIAL	
<i>9/3/58</i>		<i>Whiteville, Tenn.</i>	
22d. LOCATION (City, town, or county) (State)			
<i>Whiteville, Tenn.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
<i>The S.H. Hines Co., 2901 14th St. N.W.</i>		<i>Arthur L. Hines Sep 3 '58</i>	
24b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10355

(10355)

10377

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Maryland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. 1502 Montgomery Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joy	Middle Hazel	Last Lynes	4. DATE OF DEATH Month September	Day 21	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH September 19, 1958	9. AGE (In years lost birthday) yrs 18 hrs.	IF UNDER 1 YEAR Months 18	IF UNDER 24 HRS Days hrs.	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick E. Lynes		14. MOTHER'S MAIDEN NAME Hazel Nelson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Hazel Hynes		Address Elkridge 1502 Montgomery Road, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bilateral Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		DUE TO					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____		9/19, 1958		to _____		9/21, 1958	
alive on _____		9/21, 1958		and that death occurred at 3:00 P.M.		from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.		ADDRESS (Street, city or town, state) MARYLAND		DATE SIGNED CLARKSVILLE 9-22-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-1958		22c. NAME OF CEMETERY OR CREMATORIUM Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D. BY REGISTRAR SEP 26 1958 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10356

10288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
<i>Montgomery</i>				a. STATE	b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
<i>Takoma Park</i>		<i>13 months</i>		<i>Takoma Park</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<i>Washington Sanitarium Hosp.</i>		<i>5130 Willow Ave.</i>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
<i>William</i>	<i>Henry</i>	<i>Martin</i>	<i>Sept.</i>	<i>13</i>	<i>1958</i>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<i>M.</i>	<i>white</i>	<i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>11-24-1870</i>	<i>87</i>	Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>Retired</i>				<i>District of Columbia</i>		<i>21-S.A.</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address				
<i>William H. Martin</i>		<i>Agnes Johnson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> <i>450.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Stroke at Telic, treated</i> (c) <i>1 year</i>		
						INTERVAL BETWEEN ONSET AND DEATH <i>25 min.</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Concurrent with 16a</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>3 Sept.</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9-5-57</i> , 19 <i>58</i> , and that death occurred at <i>110 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John X. O'Brien</i>		M.D. <i>John X. O'Brien</i>		ADDRESS (Street, city or town, state) <i>7112 66th Ave NW</i>		DATE SIGNED <i>17-2-58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>9/16/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co.</i>		ADDRESS <i>Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>S. H. Hines</i>		24b. REGISTRAR'S SIGNATURE <i>S. H. Hines</i>		
				DATE <i>SEP 16 '58</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

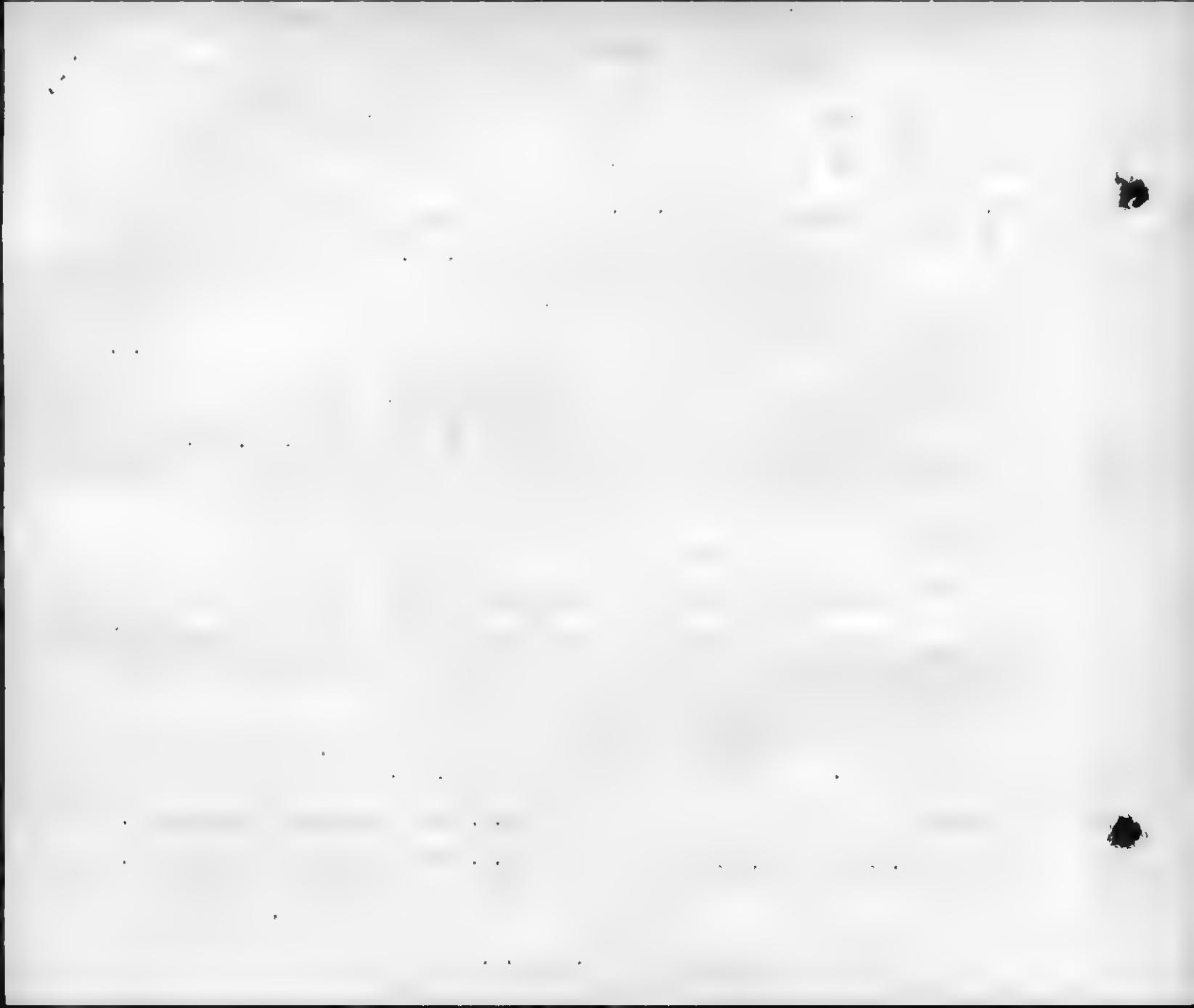
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10378 10357

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 225 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1928 Lebanon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Harry	Middle Wesley	Last MASON, Sr.	4. DATE OF DEATH September 15 1958	Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11 February 1903	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 55	11. IF UNDER 24 HRS Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME George MASON		14. MOTHER'S MAIDEN NAME Minnie BOWEN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW-II		17. INFORMANT (Son) Harry Wesley Mason, Jr. (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiomegaly, Squamous Cell</i> <i>of neck</i> DUE TO <i>15, 1958</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington	(County) Arlington	(State) Virginia
21. I certify that I attended the deceased from 2 February 1958 to 15 Sept. 1958 , that I last saw the deceased alive on 15 Sept. 1958 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>J. J. Jackie</i> ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 9-17-58								DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-19-58 22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery 22d. LOCATION (City, town, or county) Arlington, Virginia (State)								
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Jackie</i> ADDRESS Toltavull Funeral Home, 3619 14th St., Wash. D.C. 24a. REC'D BY REGISTRAR DATE SEP 19 '58								24b. REGISTRAR'S SIGNATURE <i>John J. Kraus</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10379

CERTIFICATE OF DEATH

Reg. Dist. No.

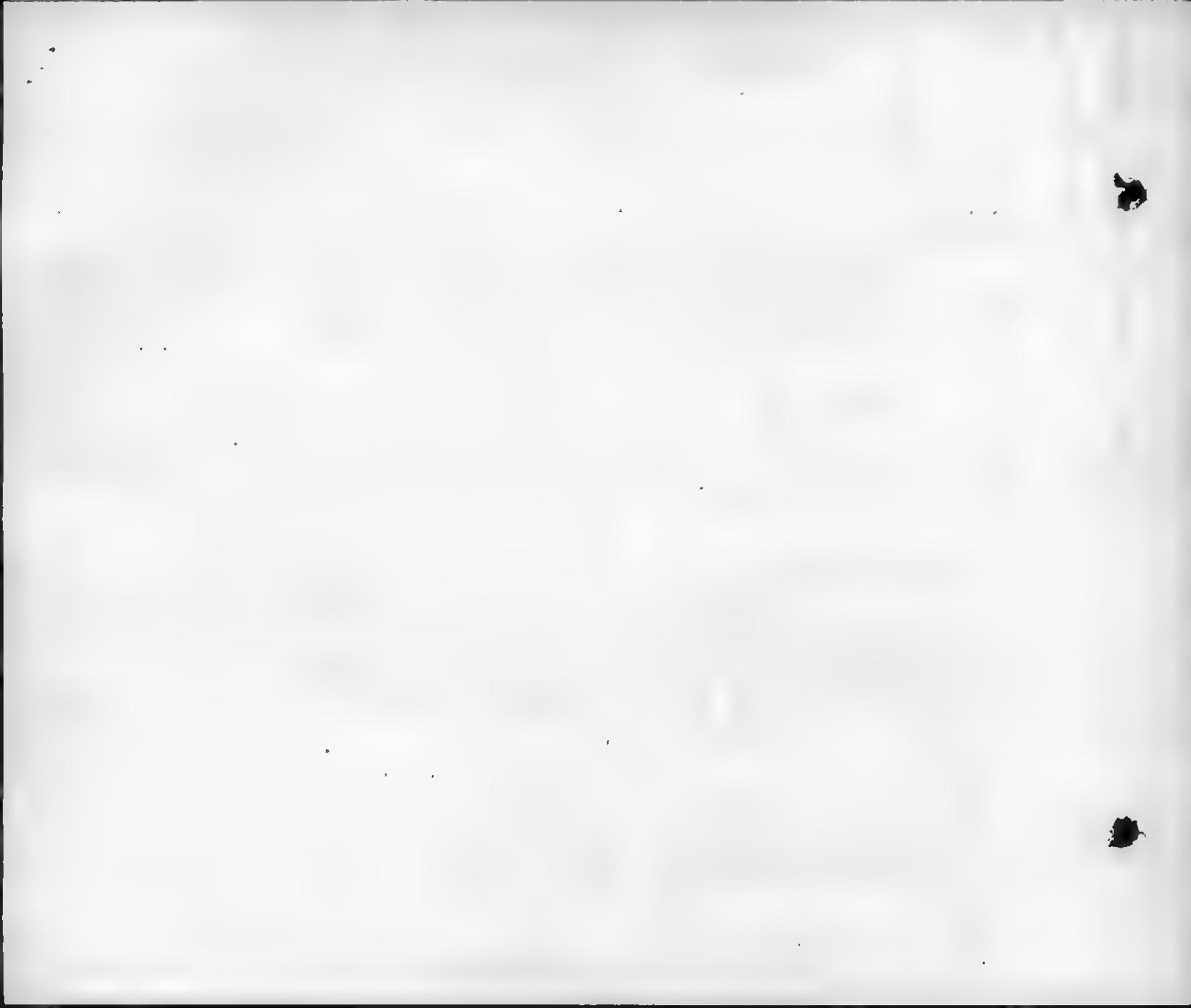
10358
215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 4909 Battery Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Diane	Middle Katherine	Last MC COMB	4. DATE OF DEATH September 4 1958	Month September	Day 4	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 23 May 1957	9. AGE (in years from birth) 1 yrs.	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington State		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Gordon Stuart MC COMB		14. MOTHER'S MAIDEN NAME Donna Margaret GALLEN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT (Father) (Same As #2) Gordon S. MC COMB	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 704.0 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 year						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month August	Doy 18	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington	(State) Virginia
21. I certify that I attended the deceased from 18 August, 1958 to 4 Sept., 1958 that I last saw the deceased alive on 4 Sept., 1958 and that death occurred at 7:45 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Robert C. Thomas</i> M.D. U.S. Naval Hospital, Bethesda, Md. 9-5-58							ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	DATE SIGNED 9-5-58
PHYSICIAN'S NAME (Type) Robert C. Thomas, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington		(State) Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE <i>E.P. Humphrey Funeral Service</i> R.A. Humphrey, 7557 Wisconsin Ave., Bethesda, Md.		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	24a. REC'D BY REGISTRAR SEP 9 '58		24b. REGISTRAR'S SIGNATURE <i>C. L. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 1SM 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

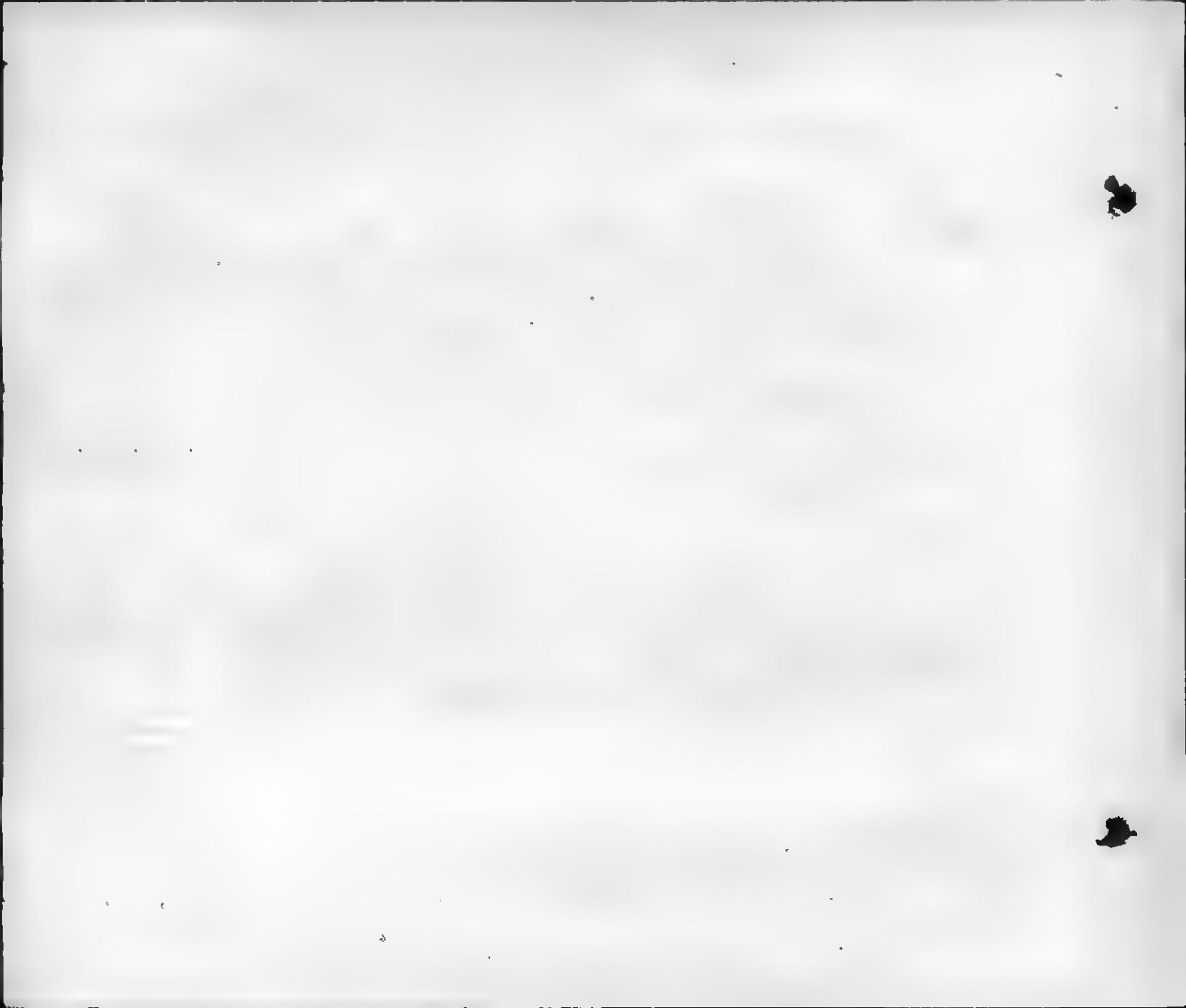
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



70

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10359	
Item 4, Film G234, 10/9/58										Reg. Dist. No.	
10289 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Takoma Park			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Takoma Park Bethesda			d. STREET ADDRESS 5112 Wessling Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ralls Nursing Home										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVA		First	Middle	Last	4. DATE OF DEATH Sept. 26 1958		Month	Day	Year		
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1886		9. AGE (in years, last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 22	12. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio							
13. FATHER'S NAME William Downes					14. MOTHER'S MAIDEN NAME Mary J. Dyal						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT daughter Helen Boyer-4708 Morgan Jr. Bh. Ch. id		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) General ARTERIOSCLEROSIS										INTERVAL BETWEEN ONSET AND DEATH 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) FRACTURE LEFT Femur - Aug. 1958										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Sept. 25</u> , 1958 to <u>Sept. 26</u> , 1958 that I last saw the deceased alive on <u>Sept. 25</u> , 1958, and that death occurred at <u>8</u> P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>Robert A. Angle</u> ADDRESS (Street, city or town, state) <u>5009 De Ray Ave., Bethesda, Md.</u> DATE SIGNED <u>Sept. 26/58</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-58		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery.		22d. LOCATION (City, town, or county) Montgomery County, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY					ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE Caroline S. Krause		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10380

CERTIFICATE OF DEATH

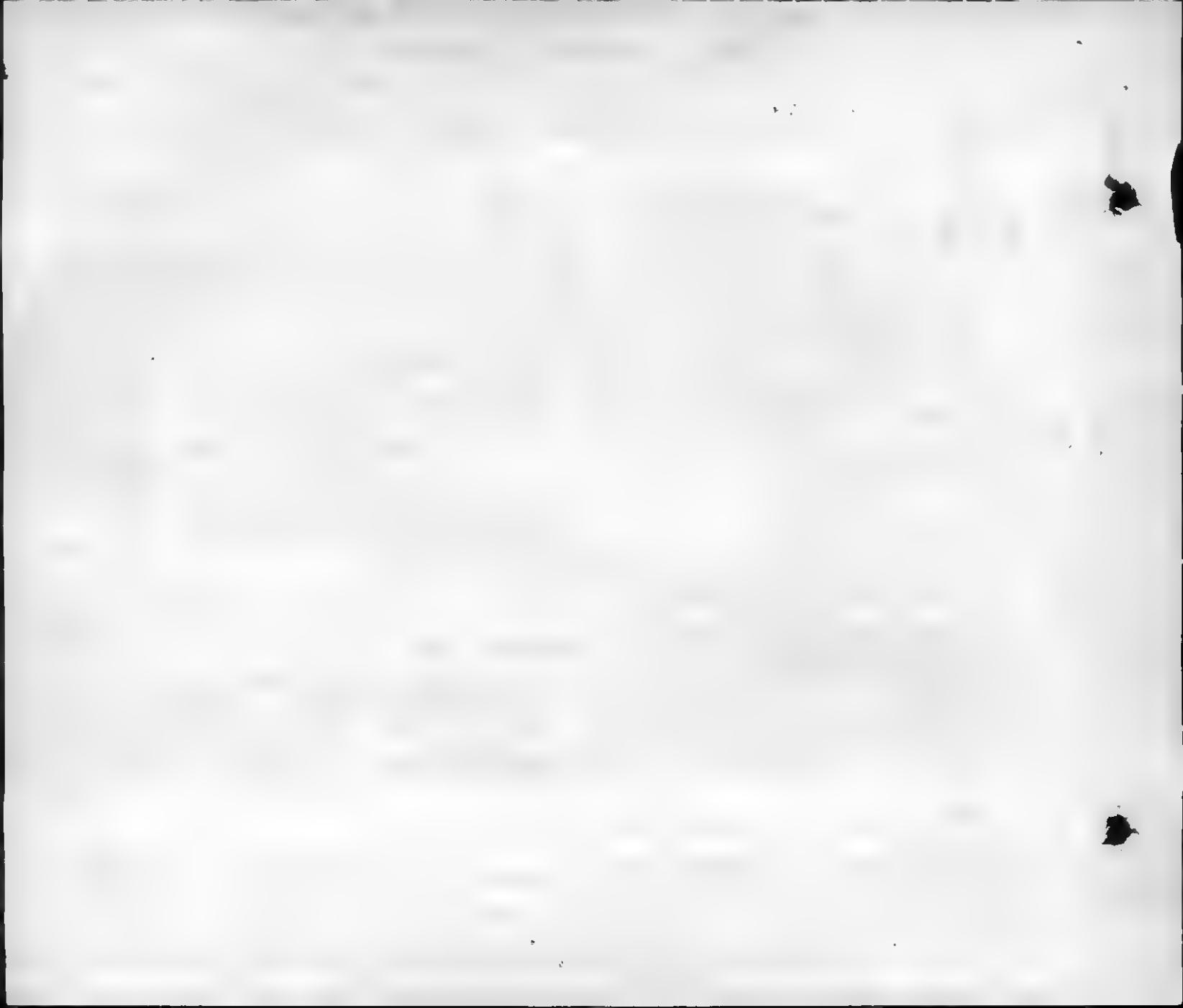
10360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 33 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
3. NAME OF DECEASED (Type or print) Norma		f. STREET ADDRESS 4209 McCain Court	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH November 4, 1872
8. AGE (in years last birthday) 85 yrs.	9. IF UNDER 1 YEAR Months 10 Days 13	10. IF UNDER 24 HRS Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROSWELL KING		14. MOTHER'S MAIDEN NAME Mary Clayton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Grand daughter (Mrs. John Gorman)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 month	
Cerebral arterio-thrombosis Generalized arteriosclerosis Hypertensive CVD		years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) gastrointestinal hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/11, 1958, to 9/16, 1958, that I last saw the deceased alive on 9/16, 1958, and that death occurred at 2:35 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE: G. Bowditch Hunter Jr. M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 9-17-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 9-17-58		22b. DATE THEREOF 9-17-58	
22c. NAME OF CEMETERY OR CREMATORIUM Beech Wood Cemetery.		22d. LOCATION (City, town or county) New Rochelle, New York (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from page 3 and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10361

10381

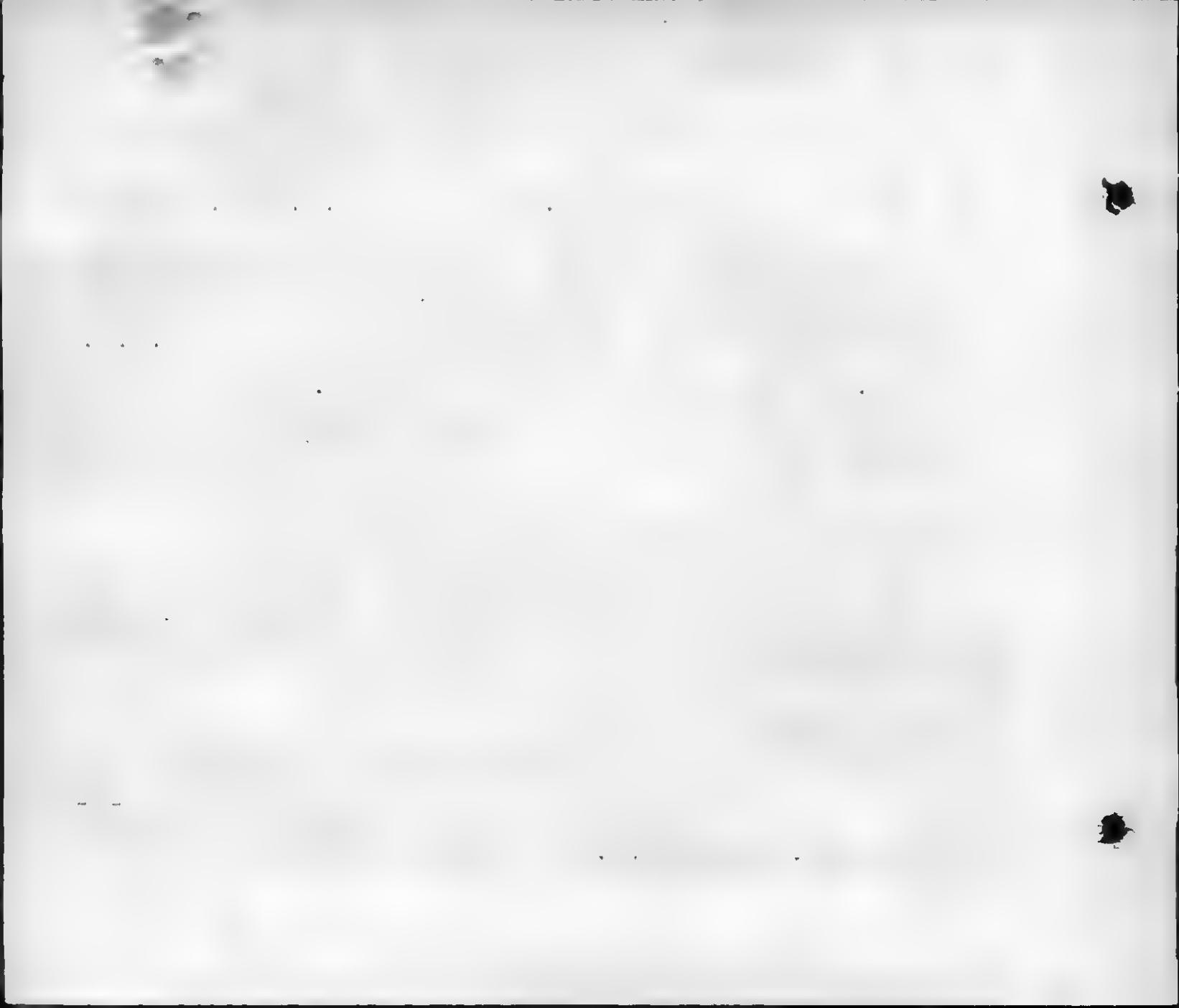
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 69 days		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print)		First Frank	Middle Ball	Lost Melchior	4. DATE OF DEATH September 15, 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 10, 1897	9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY House of Representatives		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME William E. Melchior		14. MOTHER'S MAIDEN NAME Sarah E. Ball		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No Yes		16. SOCIAL SECURITY NO 280-22-3454		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 2 wks			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157 X		Azotemia			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Metastatic carcinoma, massive		DUE TO 6 mos			
DUE TO Carcinoma of pancreas		DUE TO ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. July 8, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I attended the deceased from olive on September 15, 1958 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE H.R. Silberman PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 17 Sept 1958		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT. CEM.	
22d. LOCATION (City, town, or county) ARLINGTON, VA.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE JAMES T. RYAN, INC. 301, 317 PA. AVE. S. E. DC 3		ADDRESS 317 PA. AVE. S. E. DC 3		24a. REC'D. BY REGISTRAR SEPT 17 1958	
24b. REGISTRAR'S SIGNATURE Arthur S. Thrusd					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10362

10382

CERTIFICATE OF DEATH

Reg. Dist.-No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1717 Flora Lane		d. STREET ADDRESS 1717 FLORA LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle UNDERWOOD MILLER	Last Month Day Year 9 7 19 58
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY u.s. Govt.	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILSON P. MILLER	
14. MOTHER'S MAIDEN NAME MARY FENTON DARLEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO	16. SOCIAL SECURITY NO. NONE
17. INFORMANT MRS MARY GARDNER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442 X DUE TO cardio vascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) arterio sclerosis DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug , 19 58 , to Sept 7 , 19 58 , that I last saw the deceased alive on Sept 7 , 19 58 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1800 Baltimore St. N.W. 9-758	
ACTUAL SIGNATURE <i>E.E. Quayle</i>	M.D. E.E. Quayle M.D.	DATE SIGNED 9-7-58	
PHYSICIAN'S NAME (Type) E.E. Quayle	22d. LOCATION (City, town, or county) Washington, D.C.		
22e. BURIAL, CREMATION, REMOVAL (Specify) burial	22f. DATE THEREOF 9/10/58	22g. NAME OF CEMETERY OR CREMATORIUM Congressional Cemetery	(State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		ADDRESS 2901 14th St. N.W.	REC'D BY REGISTRAR D.GATE SEP 9 58
			24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10363

Reg. Dist. No.

10383

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 14
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. If institution, Residence before admission
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospst.		d. STREET ADDRESS '713 W. Montg. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GEORGE		First (NMI)	Middle MILLS	Last 	4. DATE OF DEATH Sept. 3, 1958	Month Sept.	Day 3	Year 1958	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/62	9. AGE (in years last birthday) 96 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 24	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Mills		Carolyn Fletcher		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs Martha M. Looper-Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446-X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 months					
(b) Cerebral Insufficiency		DUE TO (c) Meningo-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 15 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1362-2116-14-17						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) Gaithersburg		(County) Maryland	(State)
21. I certify that I attended the deceased from Sept. 17, 1958 , to Sept. 17, 1958 , that I last saw the deceased alive on Sept. 1, 1958 , and that death occurred at 3 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 26 N. Washington St., Gaithersburg, Md.		DATE SIGNED Sept. 17, 1958			
ACTUAL SIGNATURE Gordon S. Rosenberger									
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak		22d. LOCATION (City, town, or county) Gaithersburg, Maryland		(State) 			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 9/5/58		24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Maryland							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10364

10384

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 809 Crothers Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Margaret	Middle Ellen	Last MOORE	4. DATE OF DEATH	Month September	Day 8	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 22 March 1894	9. AGE (In years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months 0	Days 0	11. IF UNDER 24 HRS Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James REAL			14. MOTHER'S MAIDEN NAME Ellen BARBER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) No		16. SOCIAL SECURITY NO. 011 03 7218		17. INFORMANT (Daughter) Mrs. Edna M. Smith (Same As #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident						INTERVAL BETWEEN ONSET AND DEATH 4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 162.1		DUE TO (b) Possible metastases from bronchogenic cancer		DUE TO (c)		6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 4000 Suitland Rd., Suitland, Md.		(County) Saint Mary's Co.	(State) Md.
21. I certify that I attended the deceased from 26 August 1958 , to 8 Sept. 1958 , that I last saw the deceased alive on 8 Sept. 1958 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.									DATE SIGNED 9-9-58
ACTUAL SIGNATURE <i>James M. Young</i>		M.D. U.S. Naval Hospital, Bethesda, Md. 9-9-58							
PHYSICIAN'S NAME (Type) James M. Young, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-10-58		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		22d. LOCATION (City, town, or county) 4000 Suitland Rd., Suitland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Pumpelly</i>		ADDRESS 15 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 10 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Flans</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

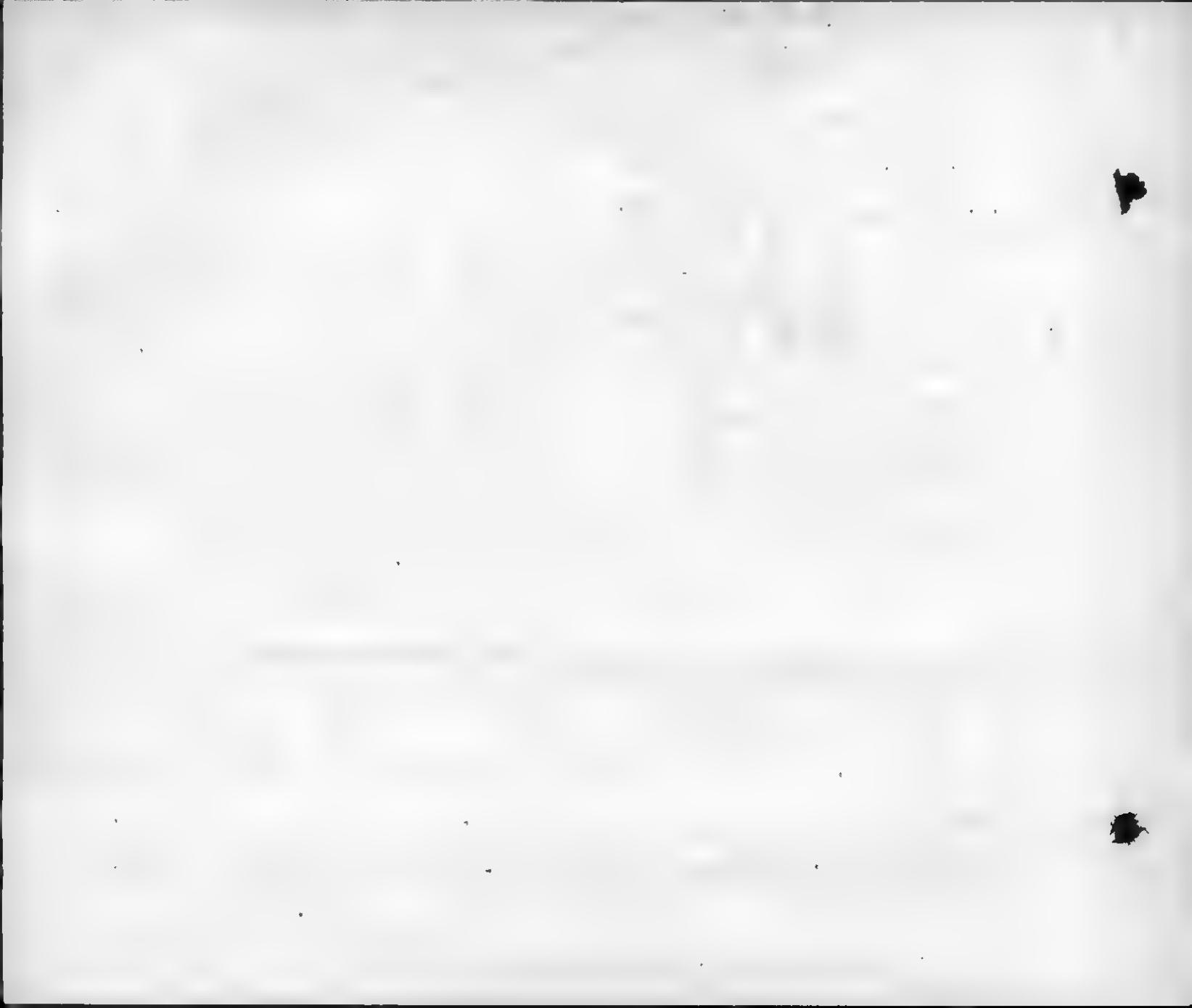
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10385

CERTIFICATE OF DEATH

Reg. Dist. No 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 53 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 432 Cross Woods Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Kathryn	Last MOORE	4. DATE OF DEATH	Month September	Day 1	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 19 January 1914	9. AGE (in years last birthday) 44 yrs	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William SHAW				14. MOTHER'S MAIDEN NAME Louisa DAWE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Theophilus MOORE (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hepatic Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Liver Metastasis DUE TO Serous Cystadenocarcinoma, Lt. Ovary with (c) Generalized Metastases INTERVAL BETWEEN ONSET AND DEATH 3 Weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 July 1958 to 1 September 1958 , that I last saw the deceased alive on 1 Sept. 1958 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-2-58							
ACTUAL SIGNATURE <i>Thomas B. Lebhertz</i> M.D.							
PHYSICIAN'S NAME (Type) Thomas B. Lebhertz, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-4-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons, 1756 Penn. Ave., Wash. D.C.				24a. REC'D BY REGISTRAR Sept 5 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

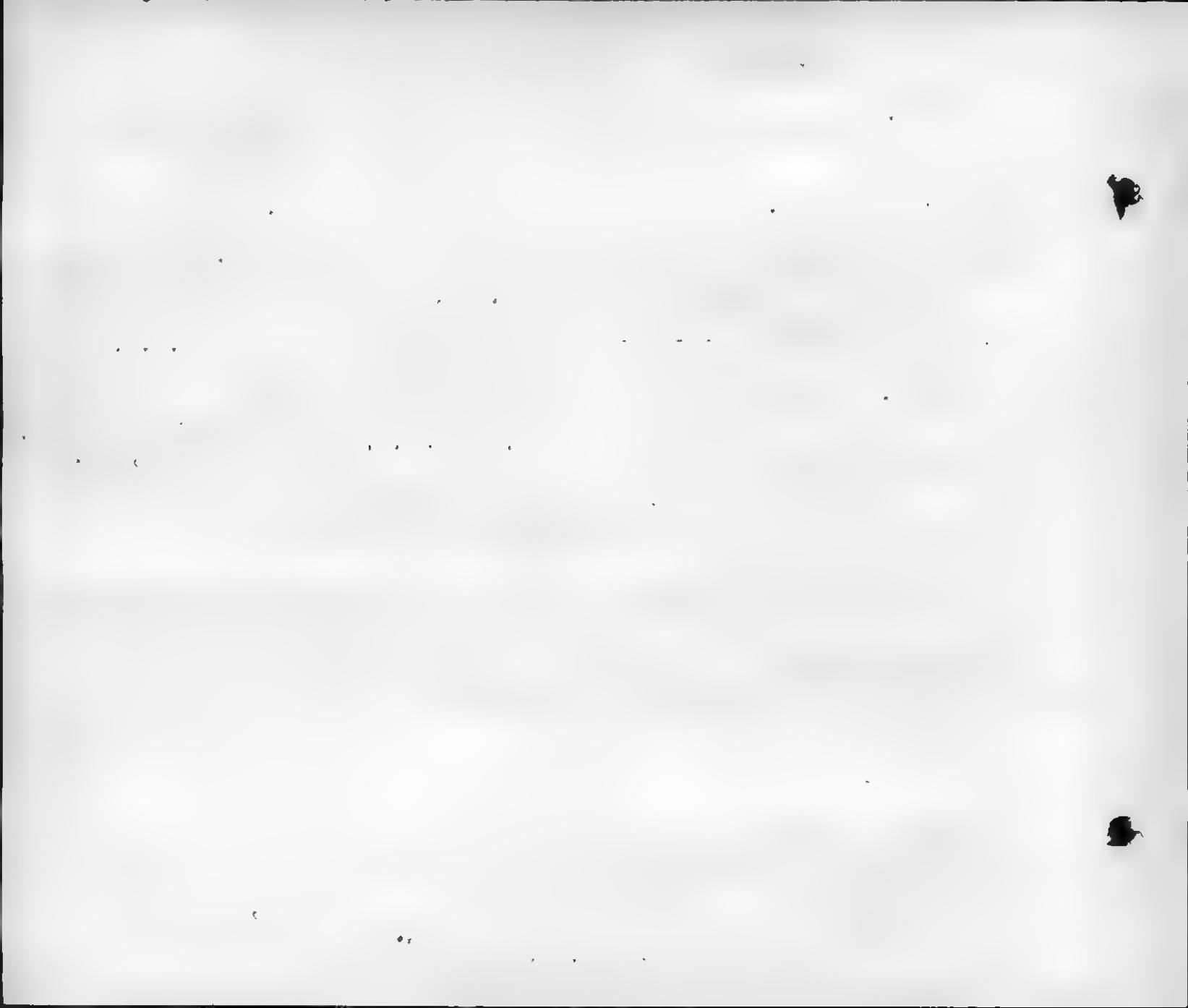
10366

10386

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONT.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. LENGTH OF STAY IN 1b 36 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glen Echo		d. STREET ADDRESS 200 Wellesley Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 Wellesley Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First NANNIE	Middle E	Last MOORE	4. DATE OF DEATH	Month Sept. 16	Day 19	Year 58		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH aug. 12, 1870	9. AGE (in years last birthday) 88	10. IF UNDER 1 YEAR Months 200	11. IF UNDER 24 HRS Days Wellesley Ave.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James E. Liddy		14. MOTHER'S MAIDEN NAME Mary Elmira Walrath							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. Ruth E.M. Long		Address 200 Wellesley Ave. Glen Echo, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 . 0		DUE TO Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 30 days					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic Heart Disease		DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 13 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Suitland, Maryland	(County) Saint Mary's Co.	(State) Maryland	
21. I certify that I attended the deceased from Aug. 14, 1958 , to Sept. 16, 1958 , that I last saw the deceased alive on Aug. 14, 1958 , and that death occurred at 1145 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) 1756 Pa. Ave. NW, DC	DATE SIGNED 9/17/58
ACTUAL SIGNATURE Leo J. Donovan	PHYSICIAN'S NAME (Type) Leo J. Donovan		M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/20/58	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lewkowicz		ADDRESS 1756 Pa. Ave. NW, DC		24a. RECD BY REGISTRAR DAT SEP 22 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Max				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10367

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and do so without delay within 72 hours after death.

1. PLACE OF DEATH		10387		Reg. Dist. No.	
a. COUNTY		Montgomery		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Barnesville		c. LENGTH OF STAY IN lb	
				50 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Celia		Thomas	Morningstar	Sept	22 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	9. AGE (In yrs, last birthday)	IF UNDER 1 YEAR Months Days Hours Min
f. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			July-22-1879	79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
carpenter		retired		Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Morningstar		Sarah Buckley		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		Dame		Mrs Russell Linda, Comes Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) severance of art. auricular artery (rt) DUE TO (c) lacrarium of scalp					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? Fracture of 2nd 3rd & 4th ribs (left) fall down stair step at home YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month Day, Year Hour a.m. 9 22 1958	
		fall down stair step at home		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) home	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-22-58	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSEHART		22a. BURIAL CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 24-58	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) Barnesville		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville Md		24a. REC'D BY REGISTRAR SEP 25 '58		24b. REGISTRAR'S SIGNATURE Albert S. Kraus	
ADDRESS					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G223 9-12-58 pt.

10388

CERTIFICATE OF DEATH

Reg. Dist. No.

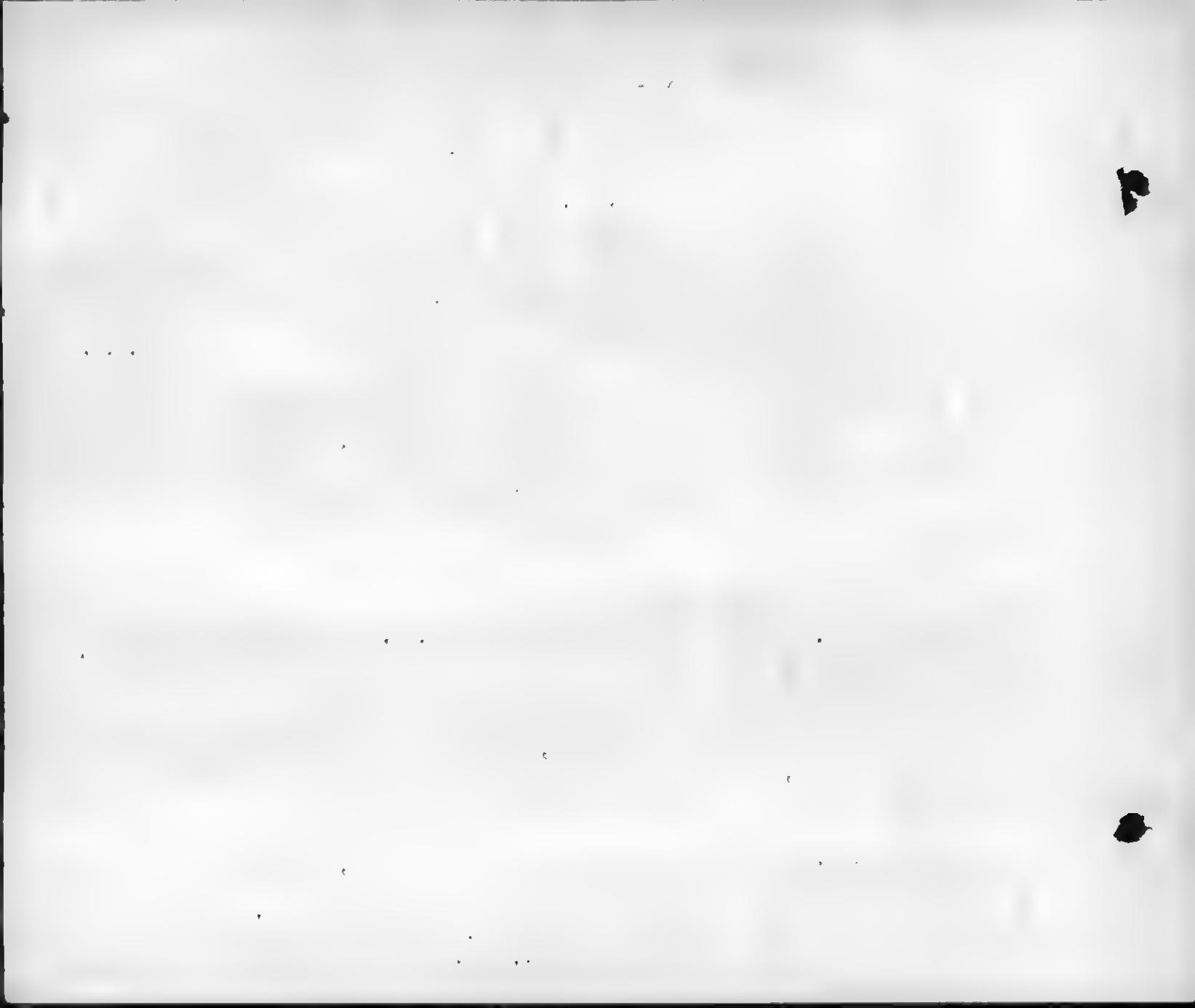
10368

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia		b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1334 South 28th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First Middle Robert Clayton Morrison		4. DATE OF DEATH Month September Day 5, Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 6, 1904	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advisor		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Manitoba		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Morrison		14. MOTHER'S MAIDEN NAME Rachel (unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Pseudomembranous Enteritis with PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage, Perforation of DUE TO Intestines and Peritonitis						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Hypertensive Cardiovascular Disease : a. Recent Myocardial Infarction. b. Chronic Congestive Heart Failure. c. Peripheral Arterial Insufficiency.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Insufficiency.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 13, 1958, to September 5, 1958, that I last saw the deceased alive on September 5, 1958, and that death occurred at 2:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>G. O. Barnett</i>						ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 9/6/58							
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cameron & Alfred Sts., Alex</i>		ADDRESS <i>Fairfax, Va.</i>		24a. REC'D BY REGISTRAR DATE SEP 8 '58		24b. REGISTRAR'S SIGNATURE <i>Reuben S. Finney</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10369

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.											
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)							
a. COUNTY		Montgomery MARYLAND		a. STATE		Maryland b. COUNTY		Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Washington Grove						Washington Grove					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS				f. IS RESIDING ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
321 Brown St.				321 Brown St							
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Vernon William Moses							Sept. 12, 1958			19	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years from birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
36		white		WIDOWED <input type="checkbox"/>		12/14/21		36 yrs		11. IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
painter				auto.				Mt Nebo, Va			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
William Moses				Sarah Keefer				USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT			
YES				285 28 5110				Address 321 Brown St, Mary Doss Moses, Washington Grove, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & Laceration											
981X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.											
(b) DUE TO											
(c) DUE TO											
Compound fracture of skull											
sudden											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
				Self inflicted shot gun wound of skull (head decapitated)							
20c. TIME OF INJURY Month, Day, Year Hour p.m. 11:30 9/12/58 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home			
								(City or town) Washington Grove (County) Montg. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
DATE SIGNED											
2. MEDICAL CERTIFICATION											
ACTUAL SIGNATURE <i>Frank J. Broschart</i>											
EXAMINER'S NAME (Type) Frank J. Broschart											
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE 9/13/58											
22a. BURIAL, CREMATION, REMOVAL (if any)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORIAL Gilgal Cemetery			
Cremation				9-13-58							
23. FUNERAL DIRECTOR'S SIGNATURE Ernest G. Gartner, Gaithersburg, Md.				ADDRESS				24a. REC'D BY REGISTRAR			
								DATE SEP 16 '58			
								24b. REGISTRAR'S SIGNATURE			
								<i>C. Gartner & Sons</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10390

CERTIFICATE OF DEATH

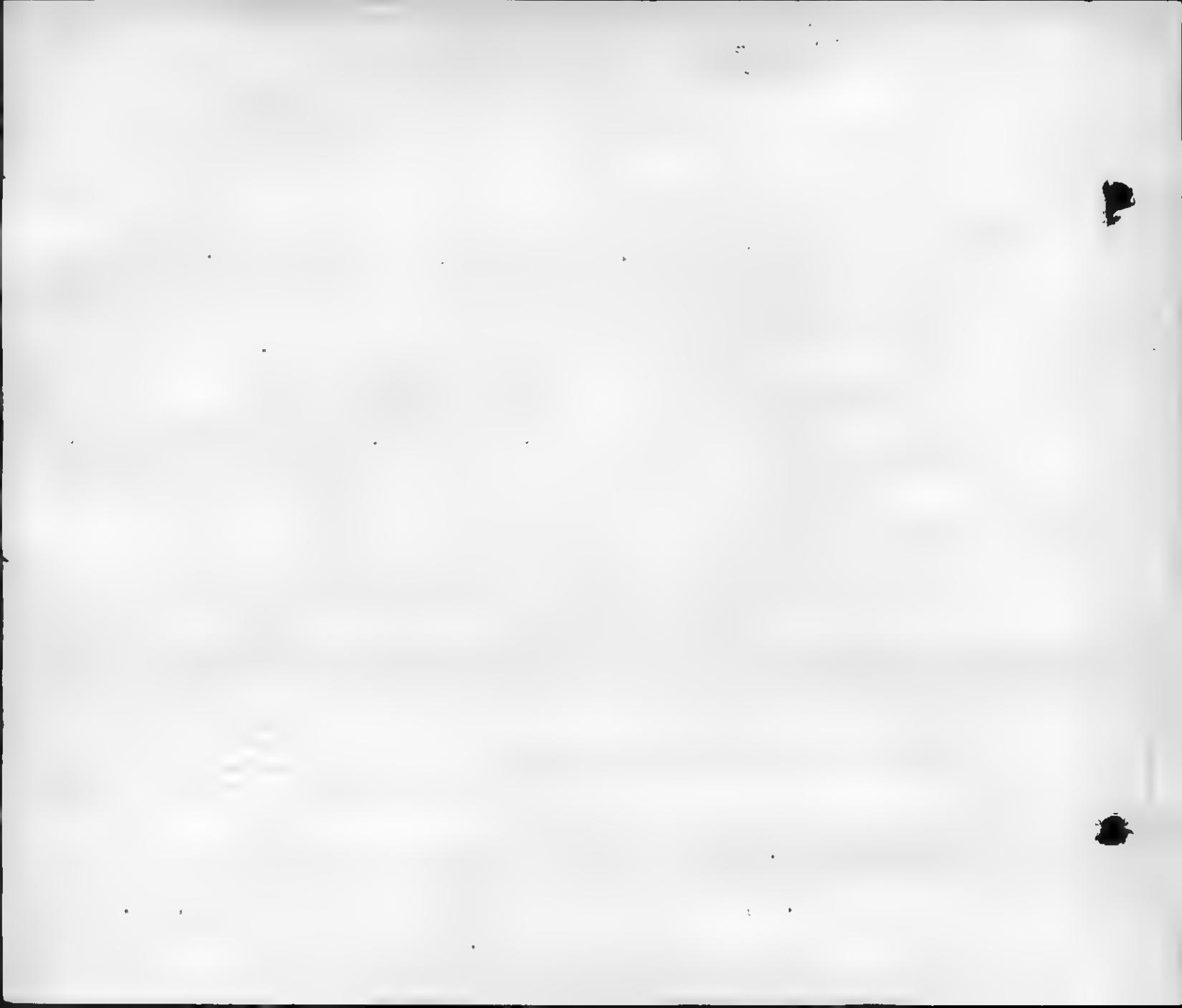
10370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Clagettsville Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Clagettsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD Monrovia			d. STREET ADDRESS RFD Monrovia		
3. NAME OF DECEASED (Type or print) Ollie W. Moxley			4. DATE OF DEATH Sept. 18 1958		
5. SEX Male White			6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1880
9. AGE (In years last birthday) 78 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		
11. BIRTHPLACE (State or foreign country) Clagettsville, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Moxley			14. MOTHER'S MAIDEN NAME Sarah Baker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO None		
17. INFORMANT Mr. Raymond M. Loxley, Monrovia, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 Adm. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ P.M., from the causes and on the date stated above. ACTUAL SIGNATURE James P. Kerr			ADDRESS (Street, city or town, state) Montgomery Neth. M.D. DATE SIGNED 10/18/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Sept. 20, 1958		
22c. NAME OF CEMETERY OR CREMATORIUM Montgomery Neth.			22d. LOCATION (City, town, or county) Clagettsville, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Oliver Molesworth			ADDRESS Danascus, Md.		
			24a. REC'D BY REGISTRAR D SEP 22 '58		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial permit. Then please remove carbon papers, fold and seal with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

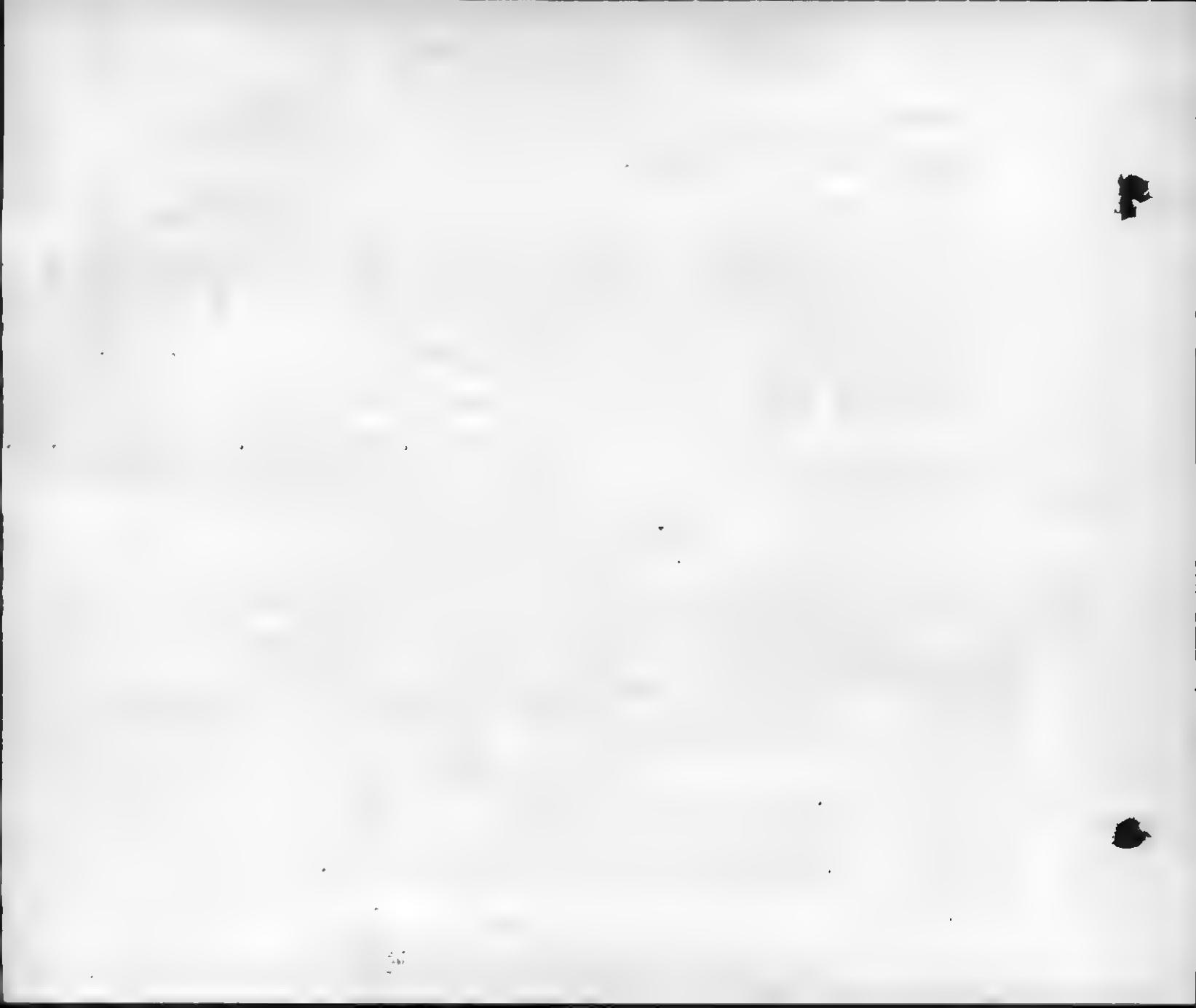
10391

CERTIFICATE OF DEATH

10371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN lb 5 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Road		d. STREET ADDRESS Box 141 Brooke Grove Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Norma	Middle Jean	Last Mullen	4. DATE OF DEATH September 18 1958	Month September	Day 18	Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/7/58	9. AGE (In years lost birthday) Yrs 5	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS Days 12	Hours Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Norman Eugene Mullen				14. MOTHER'S MAIDEN NAME Merle Elaine Hopkins				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		Address Montgomery Co. General Hosp. Records, Olney, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension - Hypertension - Bronchitis - Pneumonia - INTERVAL BETWEEN ONSET AND DEATH 10 hours 3 days								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Motor vehicle accident -						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rockville	(County) Montgomery	(State) Md.	
21. I certify that I attended the deceased from May 7 , 1958 to Sept 18 , 1958, that I last saw the deceased alive on Sept 17 , 1958, and that death occurred at 2:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md.								
DATE SIGNED Sept 18 1958								
ACTUAL SIGNATURE R. L. Snowden		PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/58		22c. NAME OF CEMETERY OR CREMATORIUM Sandy Spring		22d. LOCATION (City, town, or county) Sandy Spring, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR SEP 24 1958		24b. REGISTRAR'S SIGNATURE E. H. S. Haas		



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10392

CERTIFICATE OF DEATH

10372

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. II institution: Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 8 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hosp.		d. STREET ADDRESS RFD # 3 Mt. Airy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Dora	Middle S.	Last Mullinix	4. DATE OF DEATH Sept. 7	Month 1958	Day 7	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Clarksburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. King		14. MOTHER'S MAIDEN NAME Addie C. Hurley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No	16. SOCIAL SECURITY NO. Bone	17. INFORMANT Claude G. Mullinix, Mt. Airy, Md.	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral & General Arteriosclerosis Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular-Renal Disease c DUE TO Hypertension. (c)		INTERVAL BETWEEN ONSET AND DEATH July 9, 1958 10 yrs. 20 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18) None					
20c. TIME OF INJURY Hour o. m. p. m.	Month — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Long Corner	(County) Howard Co.	(State) Md.	
21. I certify that I attended the deceased from January 29, 1958, to September 7, 1958, and I last saw the deceased alive on Sept. 6, 1958, and that death occurred at 5:16 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Druid Theatre Building, Damascus, Maryland.							
ACTUAL SIGNATURE <i>M. McKendree Boyer, M.D.</i>	DATE SIGNED 9/7/58						
PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 9, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Howard Chapel	22d. LOCATION (City, town, or county) Long Corner, Howard Co., Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olivia Molsworth</i>	ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR DATE SEP 10 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10373

10393

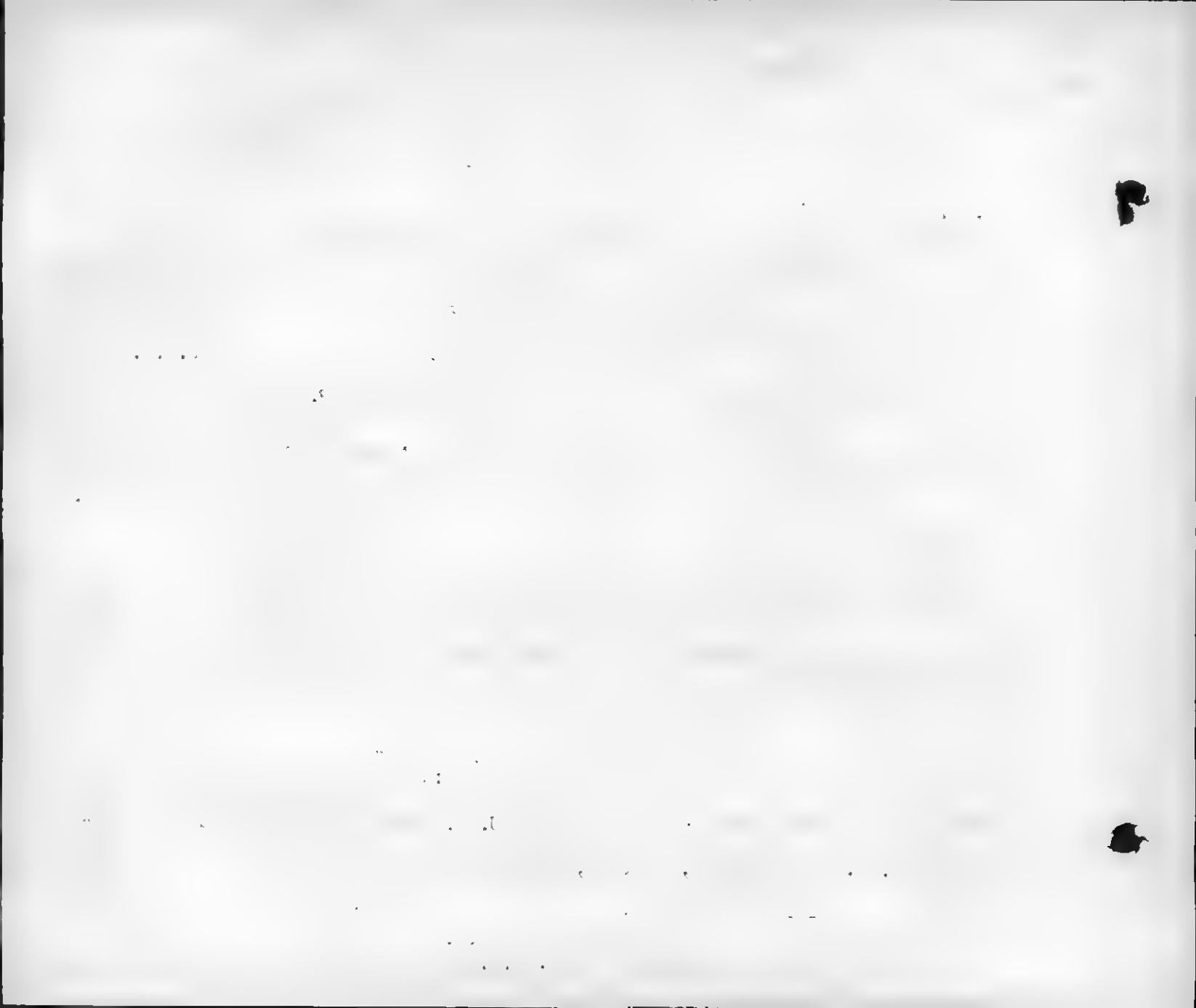
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Delaware b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS RD #4				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Elizabeth	Middle Ann	4. DATE OF DEATH	Month September	Doy 30	Year 1958	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 30, 1958	9. AGE (in years last birthday) yrs 6	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Paul Alexander MUSPRATT				14. MOTHER'S MAIDEN NAME Loretta Rebecca PULLEN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father, Paul A. Muspratt, same as #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tetralogy of Fallot</u> 7540 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While Not while or work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9-24-1958 to 9-30-1958, that I last saw the deceased alive on 9-30-1958, and that death occurred at 2:40P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED ACTUAL SIGNATURE <u>J. E. Mc CLENATHAN</u> M.D. U. S. Naval Hospital, NNM 10-1-58								
PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN Bethesda 14, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-58		22c. NAME OF CEMETERY OR CREMATORIUM Silver Brook Cemetery		22d. LOCATION (City, town, or county) Wilmington (State) Delaware		
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. D. Adams</u>		ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE OCT 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank		
Adams Funeral Home, 4748 Wisconsin Ave., N.W.								

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10374

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		10394 Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
		MARYLAND		b. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Chevy Chase 12 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS x Chevy Chase 4105 Sycamore St	
3. NAME OF DECEASED (Type or print)		First LILIAN	Middle Haigh	4. DATE OF DEATH Sept 30	Month Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH 6-9-1902	9. AGE (In years from birthday) 56 yrs
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
Housewife				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm Haigh		14. MOTHER'S MAIDEN NAME Lillian Cox		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO None		17. INFORMANT Jan Nicholl 3508 O St., Wash. D.C.	
No					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 977X		Found dead in bath room at home			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Lacerations of left wrist			
(b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Multiple sclerosis 30 x yrs					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18). Self inflicted laceration of left wrist			
CAUSE OF DEATH					
20c. TIME OF INJURY Month, Day, Year Hour 7 P.M. 9-30 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chevy Chase Minty Md	
				(City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		DATE SIGNED Frank J. Broshart			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-58		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.	
				22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS ROBERT A. PUMPHREY Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 2.58	
				24b. REGISTRAR'S SIGNATURE Emmett L. Kiernan	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10375

10395 CERTIFICATE OF DEATH

Items 2, 11, 13, 14 Film G234 10-15-58 et Reg. Dist. No.

INSTRUCTIONS

24 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN)	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY ? ?
Silver Spring, Md. 20901	2 yrs	X	?
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marlboro Rest Home, 1651 Old Village Rd.		STREET ADDRESS	? (If rural give location)
3. NAME OF (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Catherine		Sept 27 1958	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Now	8. DATE OF BIRTH Month
9. AGE last birthday 81 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) ? ?
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ?	
14. MOTHER'S MAIDEN NAME ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS 2nd and 18. Silver Spring	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 22 IX IMMEDIATE CAUSE (A) <i>Berebral Vasculitis Accident</i> ANTECEDENT CAUSE(S) DUE TO <i>Ischaemic stroke</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>None</i> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>None</i> (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-3-1958</u> , to <u>9-27-58</u> , that I last saw the deceased alive on <u>9-25-1958</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. SIGNATURE <i>John D. Rogers</i> M.D. <i>1918 Longmeadow Rd 9-27-58</i> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-1-58	NAME OF CEMETERY OR CREMATORIAL Mon. Co. Rockville
24. REC'D BY REGISTRAR DATE OCT 2 '58		REGISTRAR'S SIGNATURE <i>Cathleen S. French</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ernest C. Gartner, Galters



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10396

CERTIFICATE OF DEATH

Reg. Dist. No.

1037

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First James	Middle Steven	Last Offutt	4. DATE OF DEATH Month September Day 24 Year 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/27/45	9. AGE (In years last birthday) 13 yrs.	10. IF UNDER 1 YEAR Months 13	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jerome Offutt				14. MOTHER'S MAIDEN NAME Mary Loretta Davis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Chart		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bacterial 744.1 DUE TO Bronchio INTERVAL BETWEEN ONSET AND DEATH 4 days.</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pseudo-hypertrophic (c) Muscular Dystrophy 11 year,</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 491X</p>								
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)</p>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Sept. 21, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Barnesville	(County) Montgomery	(State) Md.
<p>21. I certify that I attended the deceased from Sept. 21, 1958 to Sept. 24, 1958, that I last saw the deceased alive on Sept. 24, 1958, and that death occurred at 9 AM M, from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) Barnesville, Md.</p> <p>DATE SIGNED Sept. 25, 1958</p>								
<p>MEDICAL CERTIFICATION</p> <p>ACTUAL SIGNATURE Jack Schumacher M.D.</p> <p>PHYSICIAN'S NAME (Type) Dr. Jack Schumacher Gaithersburg, Md.</p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27-58		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's		22d. LOCATION (City, town, or county) Barnesville (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Willis B. Hilton, Barnesville, Md.		ADDRESS		24a. REC'D DAY REGISTRAR SEPT 29 1958		24b. REGISTRAR'S SIGNATURE W. B. Hilton		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

CERTIFICATE OF DEATH

Reg. Dist. No.

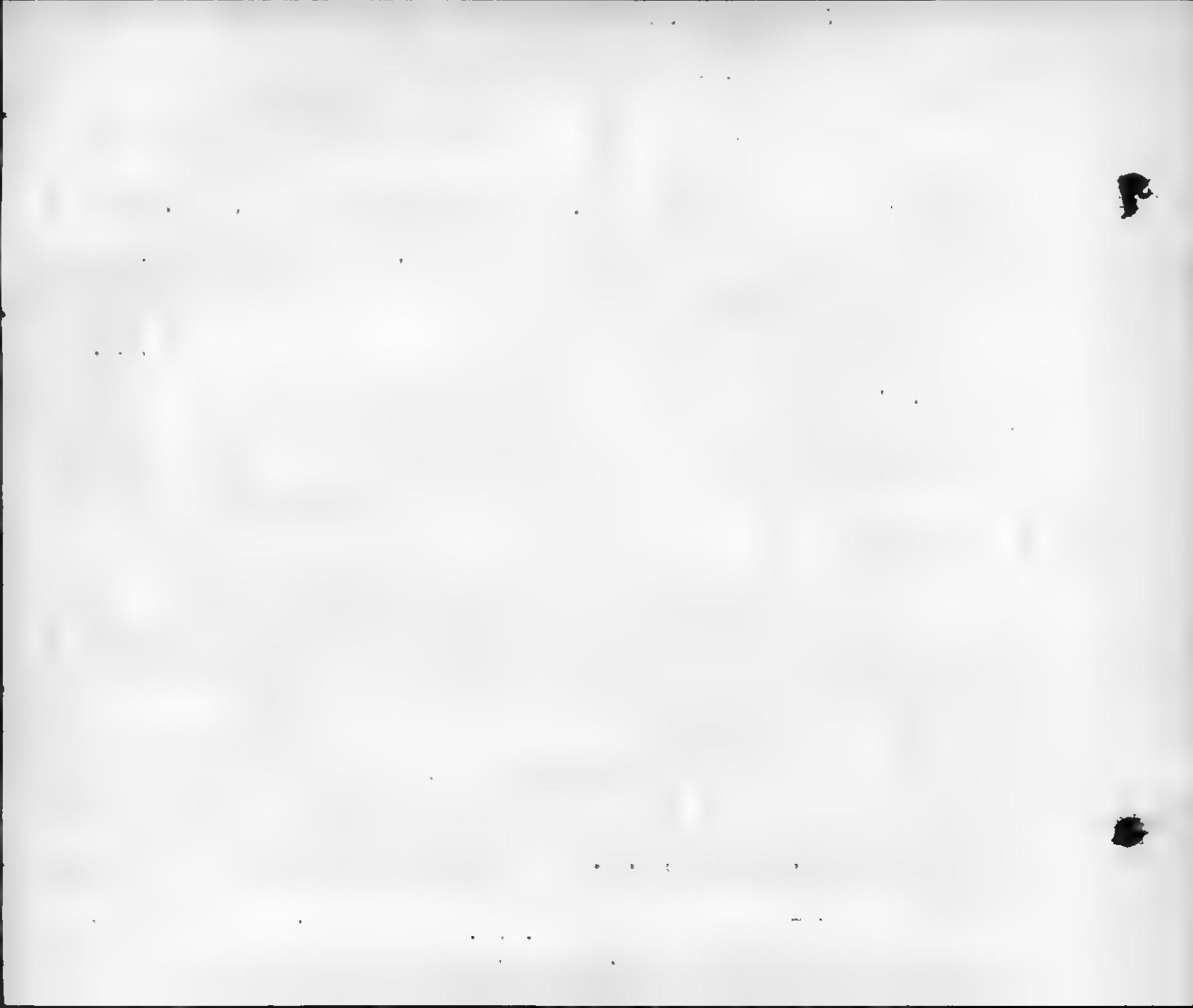
10377

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 57 days		a. STATE District of Columbia		b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2915 Connecticut Avenue, N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) James William O'Hara, Sr.		First	Middle	Last	4. DATE OF DEATH September 4, 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	Days	Hours	IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Agent		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James J. O'Hara		14. MOTHER'S MAIDEN NAME Ellen Kelly							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) yes		16. SOCIAL SECURITY NO. 706-14-8228		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 144X DUE TO <i>respiratory arrest - cerebral ischemia</i>						INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>uremia</i> DUE TO (c) <i>hypertension</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 9, 1958 to September 4, 1958 , that I last saw the deceased alive on September 4, 1958 , and that death occurred at 9:55 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 9/5/58			
ACTUAL SIGNATURE Eugene B. Feigelson		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Eugene B. Feigelson, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-2-58		22b. DATE THEREOF 14th. St. N.W.		22c. NAME OF CEMETERY OR CREMATORIUM GS P. TR. PAUL C. M.		22d. LOCATION (City, town, or county) W. DIST. C. C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Collins		ADDRESS 14th. St. N.W.		24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10398 CERTIFICATE OF DEATH

Reg. Dist. No. 10378

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY	MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING		c. LENGTH OF STAY IN 1b		2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		10617-EDGEWOOD AVE.		d. STREET ADDRESS		10617-EDGEWOOD AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
William P. O'HARA					9	29	1958				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
M		W		NOV 25 1881	76	Yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
RETIRED		WHOLESALE BUS.		WINCHESTER MASS.		U. S. A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Francis J. O'HARA		JANE DONAHUE									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		010-10-8556		THOMAS FORD - 10617-EDGEWOOD AVE.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PULMONARY ASPIRATION - VOMITUS						SIX WEEKS			
450.0		DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		ARTERIOSCLEROTIC SENILITY		4 YRS					
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED?			
NONE								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
X											
20c. TIME OF INJURY Month, Day, Year Hour o. n. X 19 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) X		(County)		(State)	
21. I certify that I attended the deceased from 7/7 1958, to 9/29 1958, that I last saw the deceased alive on 7/25 1958, and that death occurred at 8:15 PM, from the causes and on the date stated above								ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		HARRY W. STOUT MD.		10011 Georgia Ave.							
PHYSICIAN'S NAME (Type)		HENRY W. STOUT		Silver Spring Maryland							
22a. BURIAL/CREMATION (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
X		10-2-58		MT. OLIVET		WASHINGTON D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Timothy Hanlon		3831-GA-AVE.		DATE 3 '58		Signature					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-tombstone Permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10379

10399

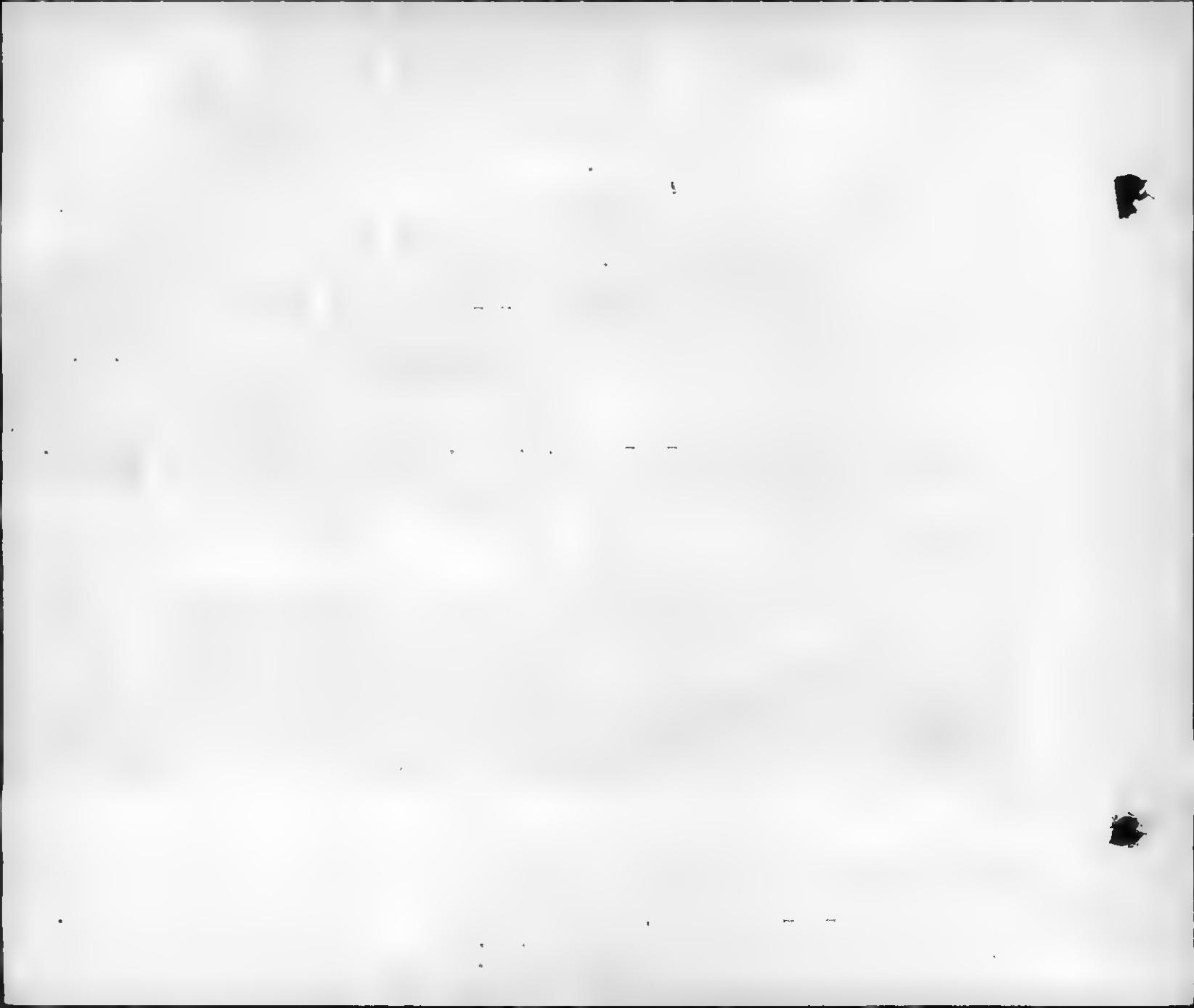
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 YRS.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8904 FLOWER AVENUE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 8904 FLOWER AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANDREW		First	Middle	Last	4. DATE OF DEATH OTT	Month 9	Day 26	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 2-1-86	9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machanist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOHN OTT		14. MOTHER'S MAIDEN NAME LOUISE SCHULER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-32-9167		17. INFORMANT RS. S.M. DEFFINBAUGH		Address SILVER SPRING, MD 8904 Flower Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
420.1		DUE TO		<i>Myocardial Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH Sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)		<i>Coronary Heart disease</i>		5 yrs			
		(c)		<i>Generalized arteriosclerosis</i>		10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 9	Day 19	Year 58	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 5801-1377	(County) M.D.	(State) Bladensburg, Maryland.
21. I certify that I attended the deceased from 9/30 , 19 57 to 9/26 , 19 58 , that I last saw the deceased alive on 9/26 , 19 57 , and that death occurred at 1277 M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 5801-1377 M.D.									
DATE SIGNED 10/1/58									
ACTUAL SIGNATURE <i>A.C. Leonardo</i>									
PHYSICIAN'S NAME (Type) A.C. LEONARDO									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-29-58	22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) Bladensburg, Maryland.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins	ADDRESS 14th, St. N. W.	WASH. D. C. 3821	24a. REC'D BY REGISTRAR SEP 30 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar (prior to burial), cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10380

10290

CERTIFICATE OF DEATH

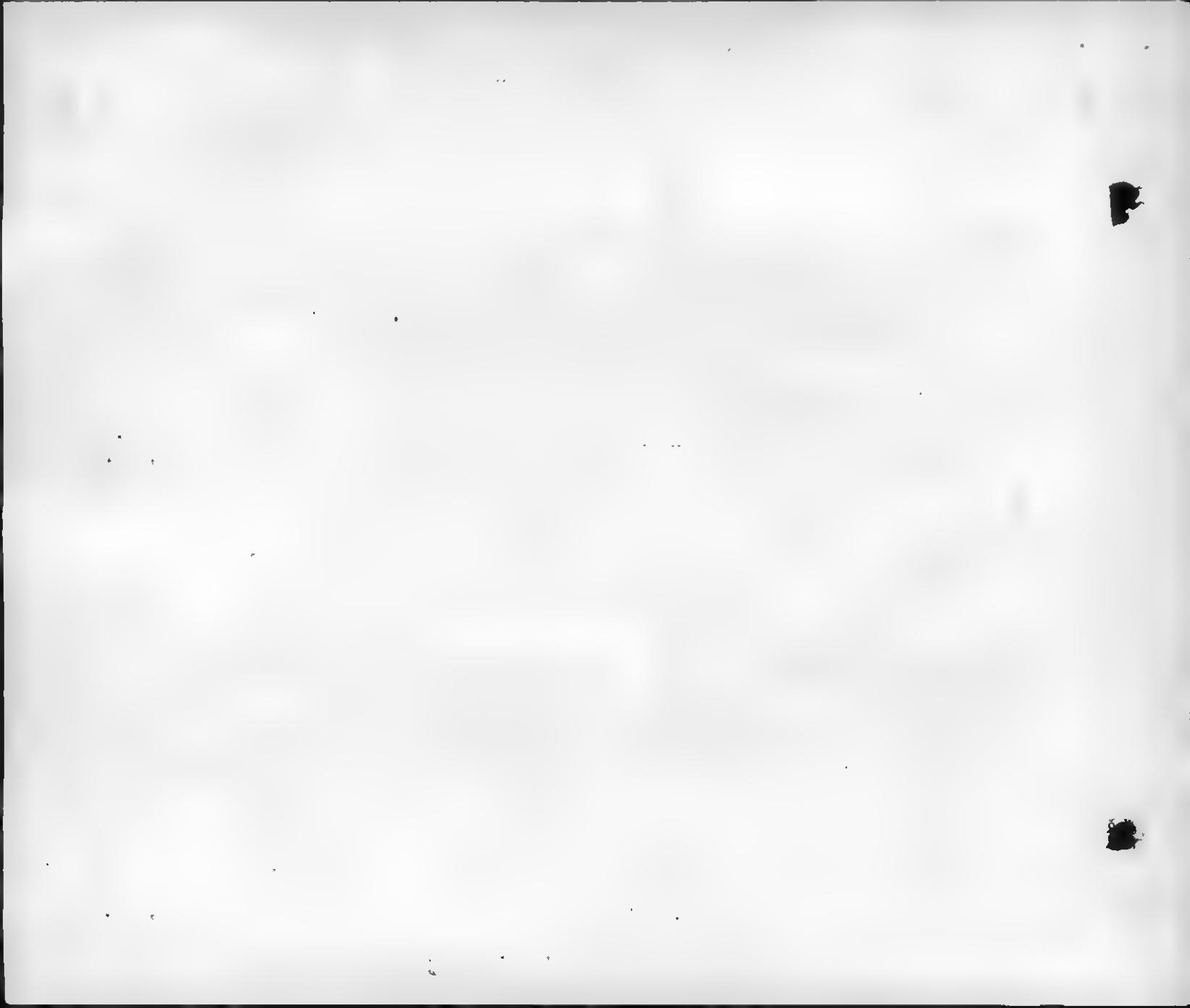
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>PRINCE GEORGE</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>Do A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ADELPHI</i>		d. STREET ADDRESS <i>8113 RIGGS ROAD</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Sanitarium + Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Andrew N MN Pappas</i>		First	Middle	Lost	4. DATE OF DEATH <i>9</i>	Month	Day	Year
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-3-98</i>	9. AGE (In years last birthday) <i>60 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>Greece</i>		
13. FATHER'S NAME <i>Peter John - Pappas</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>195-09-4339</i>		17. INFORMANT <i>John Pappas</i>		Address <i>8113 Riggs Rd., Adelphi, MD.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Sudden cardiac failure				INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Cardiac hypertrophy + initial congestive heart failure						
DUE TO (c)		Essential hypertension		2 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o.m. p.m.		Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Eino Magi</i>				ADDRESS (Street, city or town, state) <i>918 University Blvd. East, Silver Spring, Maryland</i>		DATE/SIGNED <i>9/10/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>9/12/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN CEMETERY</i>	22d. LOCATION (City, town, or county) <i>PRINCE GEORGE COUNTY, MD.</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Zicka</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 15 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. If either, notify medical examiner. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial; cremation, or removal, and in any event within 72 hours after death.

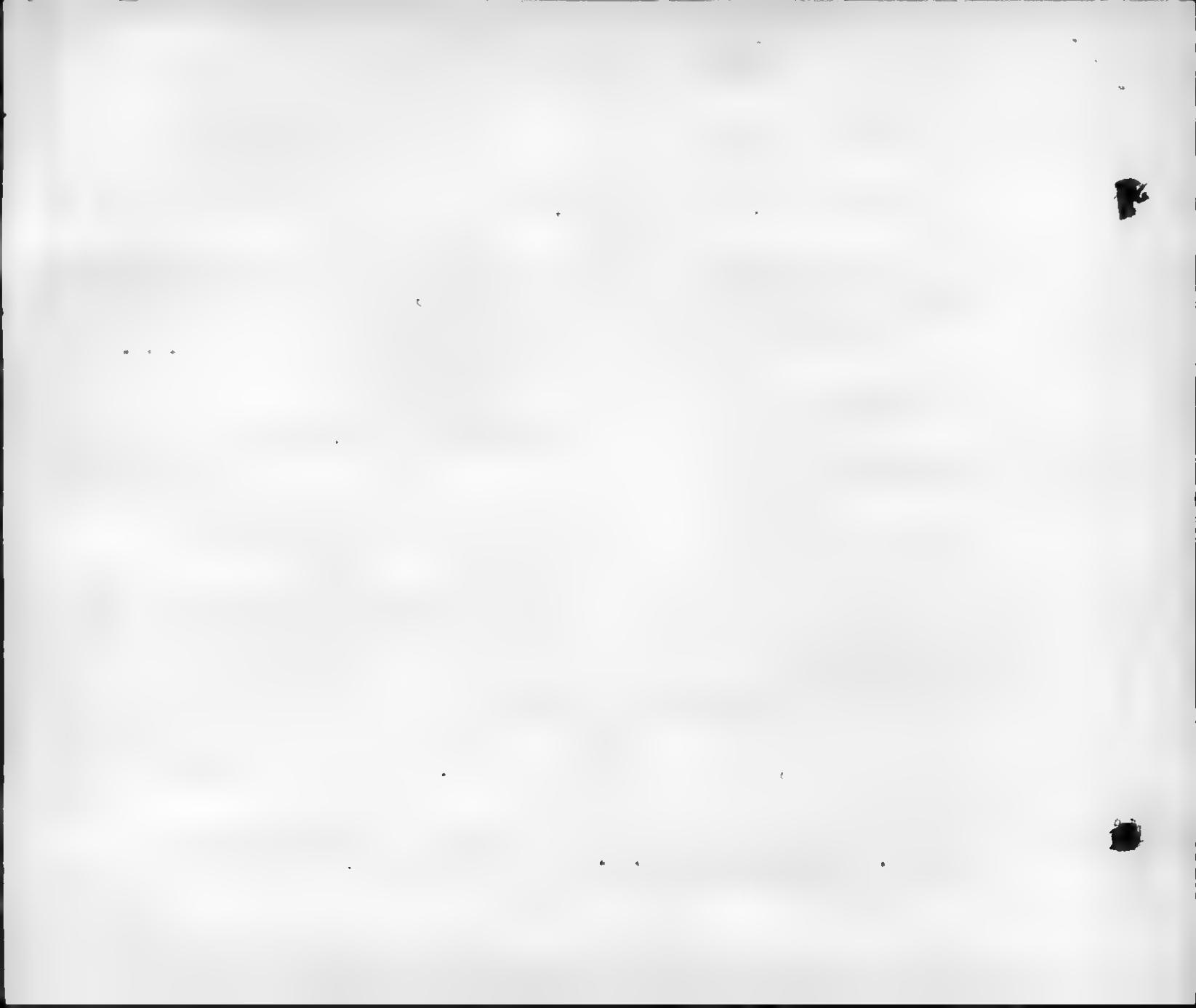
Item 18 Film 255 10-22-501 Reg. No. 9-15-58 at
10400 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10381

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey		b. COUNTY Union		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 1828 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Plainfield		d. STREET ADDRESS 203 View Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Francine		First (none)	Middle 	Last Pascale	4. DATE OF DEATH September 4, 1958	Month September	Day 4	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 27, 1932	9. AGE (In years last birthday) 25 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker		10b. KIND OF BUSINESS OR INDUSTRY Office Work		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Pascale		14. MOTHER'S MAIDEN NAME Loretta Pearly						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest						INTERVAL BETWEEN ONSET AND DEATH		
7540 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) postoperative Left subclavian-pulmonary artery anastomosis & aorto pulmonary artery bypass (c) Congenital Heart Disease, Tetralogy of Fallot								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from August 17, 1958 to September 4, 1958 , that I last saw the deceased alive on September 4, 1958 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 9/5/58		
ACTUAL SIGNATURE N. Perryman Collins		M.D.						
PHYSICIAN'S NAME (Type) N. Perryman Collins, M. D.				National Institutes of Health Bethesda 14, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/9/58		22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer		22d. LOCATION (City, town, or county) S. Plainfield, New Jersey		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 9 '58		24b. REGISTRAR'S SIGNATURE E. A. Pumphrey		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11540

10401

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>Suburban</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>608 Monroe St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Baby Girl Patterson</i>		First	Middle	Last	4. DATE OF DEATH Month <i>September 20 1958</i>	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 20 1958</i>	9. AGE in years (less birthday) yrs. <i>-</i>	10. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Ernest Dennis Patterson</i>		14. MOTHER'S MAIDEN NAME <i>Vivian Elizabeth Heath</i>		Address <i>2210 11th St.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>-</i>		17. INFORMANT <i>-</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO <i>196X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <i>-</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>-</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>		20f. (City or town) (County) (State) <i>-</i>	
21. I certify that I attended the deceased from <i>9-20-58</i> , 19 <i>58</i> , to <i>9-20-58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9-20-58</i> , 19 <i>58</i> , and that death occurred at <i>8:10 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>John K. Bentley</i>		M.D. <i>Dr. John K. Bentley 2716 Howard Ave., Baltimore, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>9-23-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Suburban Lodge</i>		22d. LOCATION (City, town, or county) (State) <i>Bethesda Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>-</i>		ADDRESS <i>-</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10402

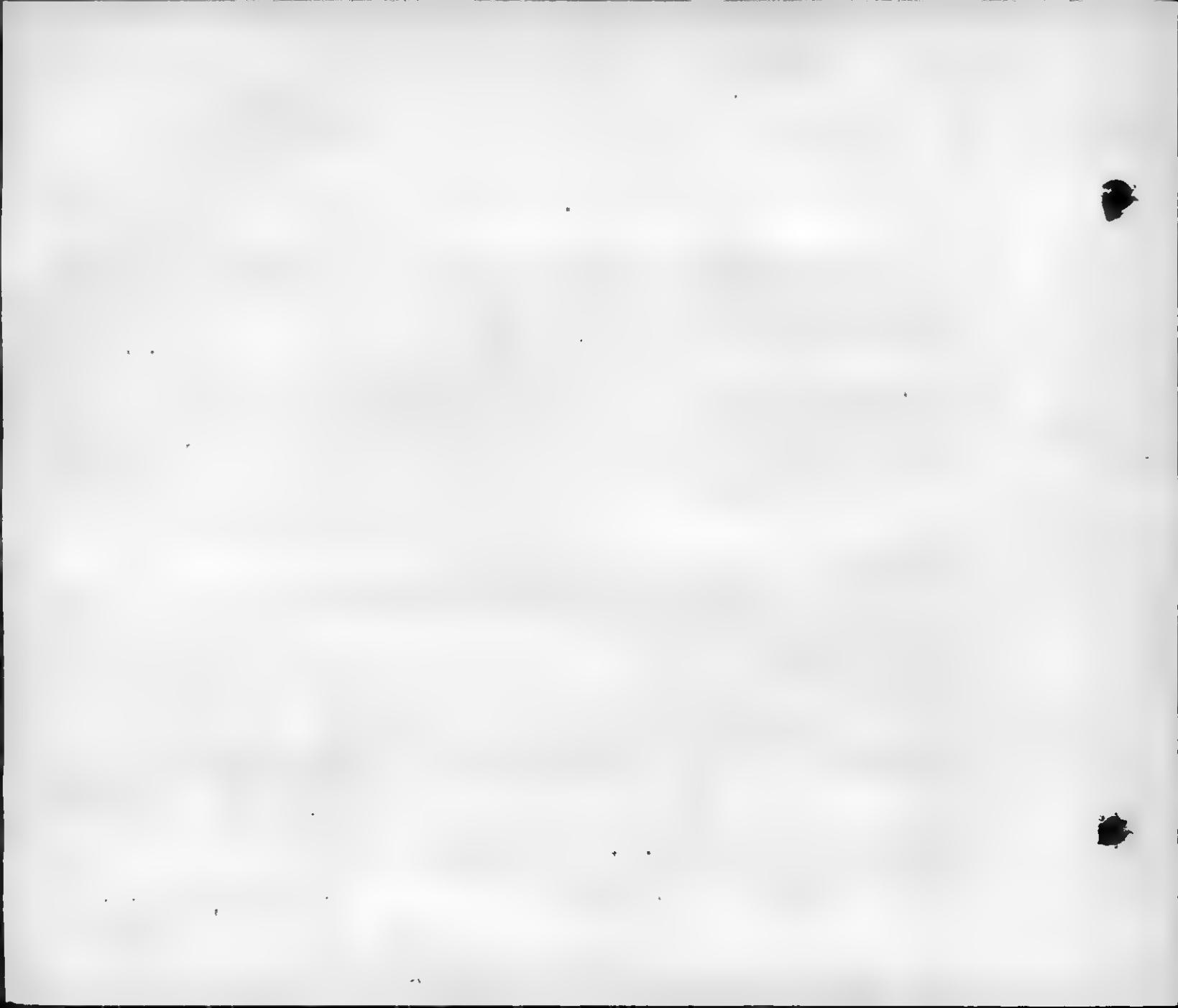
CERTIFICATE OF DEATH

Reg. Dist. No. 10382

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church		d. STREET ADDRESS 1318 Chestnut Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Franklin	Middle Ray	Last Payne	4. DATE OF DEATH September 16	Month 1958	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1921	9. AGE (In years lost birthday) 37 yrs.	IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation		10c. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Inmon H. Payne		14. MOTHER'S MAIDEN NAME Goldie Stickles					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no or unknown) no		16. SOCIAL SECURITY NO 231-12-9548		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Acute Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 30 minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Congestive Heart Failure		4 months			
		(c) DUE TO Rheumatic Heart Disease		?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Possible Laennec's Cirrhosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 3, 1958, to September 16, 1958, that I last saw the deceased alive on September 16, 1958, and that death occurred at 2:10 A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 9/16/58	
ACTUAL SIGNATURE Jean Donald Wilson		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Jean Donald Wilson, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORIUM Hillsboro		22d. LOCATION (City, town, or county) (State) Hillsboro, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Money & King Funeral Home,		ADDRESS 171 Maple Ave. W. Vienna, Va.		24a. REC'D BY REGISTRAR SEP 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, it may be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be retained until the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10383

CERTIFICATE OF DEATH

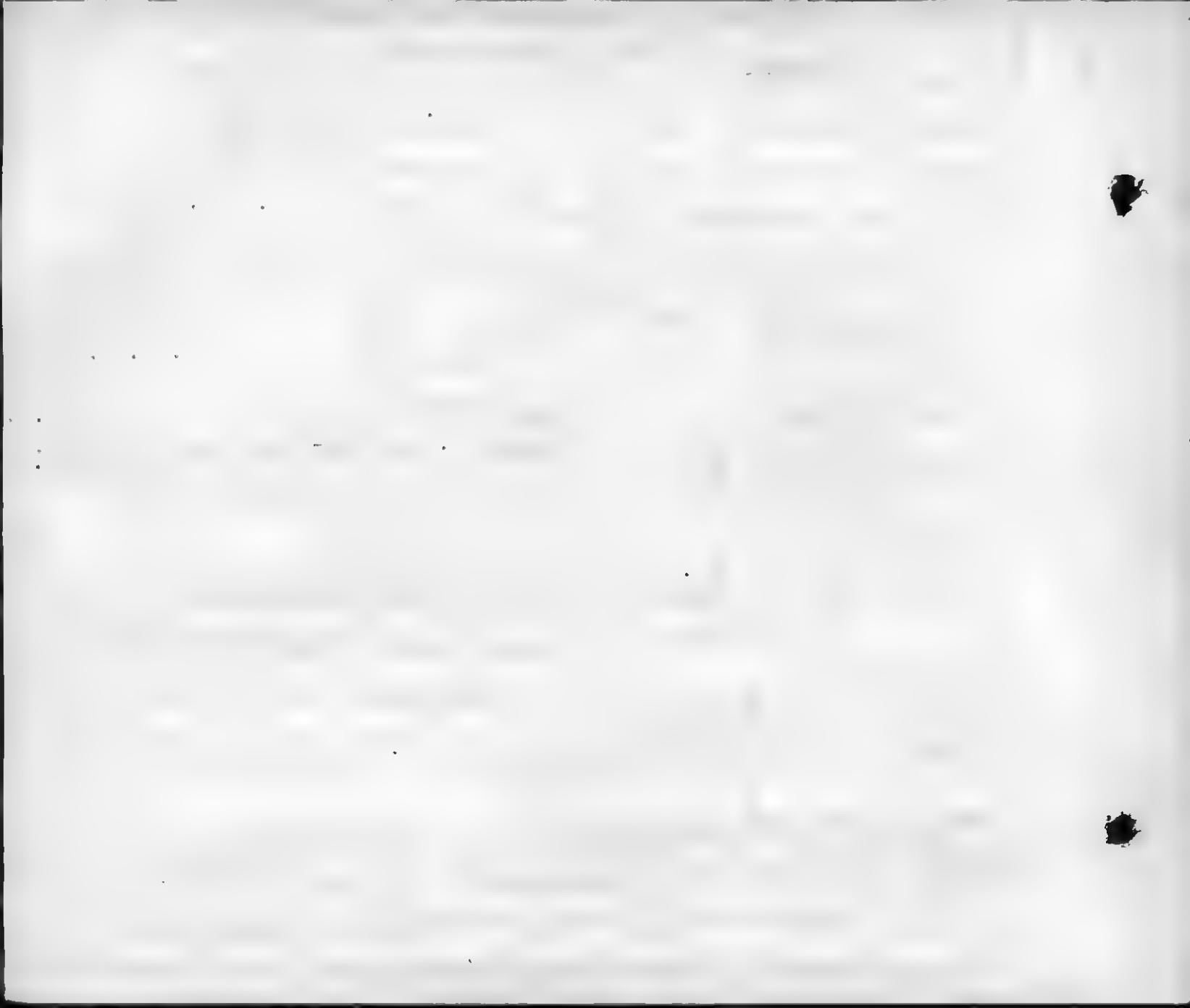
Reg. Dist. No.

10403

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium		d. STREET ADDRESS 5226 MacArthur Blvd. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First REULAH	Middle	Last PENDILL	4. DATE OF DEATH SEPT 26 1958	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 17, 1885	9. AGE (In years from last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan	
13. FATHER'S NAME Raymond Rogers		14. MOTHER'S MAIDEN NAME Ruby Shedd		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Vivian M. Struble-5226 MacArthur Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS				INTERVAL BETWEEN ONSET AND DEATH W	
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) HYPERTENSIVE HEART DISEASE			
		DUE TO (c) ESSENTIAL HYPERTENSION			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		PERICARDITIS WITH EFFUSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) APRIL 19, 1958 to SEPI. 26, 1958			
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 5206 Norway Dr.	(County) (State) MD
21. I certify that I attended the deceased from APRIL 19, 1958 to SEPI. 26, 1958 , that I last saw the deceased alive on SEPT 26, 1958 , and that death occurred at 14 PM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) 5206 Norway Dr., Chevy Chase, Md.					
DATE SIGNED 1/58					
ACTUAL SIGNATURE Raymond Rogers, M.D.					
PHYSICIAN'S NAME (Type) CHEUV CHASE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 9/27/58	22c. NAME OF CEMETERY OR CREMATORIUM Burlington Cemetery	22d. LOCATION (City, town, or county) Burlington, Michigan	(State) MI	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Nine Co.	ADDRESS 2901-14th St. N.W. Wash. D.C.	24a. REC'D BY REGISTRAR SEP 29 '58	24b. REGISTRAR'S SIGNATURE John E. Hause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10404

CERTIFICATE OF DEATH

10384

Reg. Dist. No

1. PLACE OF DEATH a COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
Montgomery				b. STATE District of Columbia	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 38 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d STREET ADDRESS 14 Quincy Place, N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Sudie	Middle Mae	Last Phillips	4. DATE OF DEATH September 4 1958
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1922	9. AGE (In years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Upholstering		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME George W. Phillips		14. MOTHER'S MAIDEN NAME Lena Murphy		12. CITIZEN OF WHAT COUNTRY U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO 242-34-0196		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH 158.6 CONGESTIVE HEART FAILURE			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO (b) AORTIC INSUFFICIENCY			
		DUE TO (c) MARFAN'S SYNDROME 36 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28, 1958, to September 4, 1958, that I last saw the deceased alive on September 4, 1958, and that death occurred at 5:05 A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state)		DATE SIGNED 9/5/58			
ACTUAL SIGNATURE <i>John A. Oates, Jr., M.D.</i>		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) John A. Oates, Jr., M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-7-58		22c. NAME OF CEMETERY OR CREMATORIAL Church	
22d. LOCATION (City, town, or county) Aysden, N.C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. R. Bacon 172-78 STN 1</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
				24b. REGISTRAR'S SIGNATURE <i>C. H. 9-8-58</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10405

CERTIFICATE OF DEATH

10385

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

Maryland

b. COUNTY

Md.

b. CITY OR TOWN (If outside corporate limits, write
in full, or if rural, give nearest town)

5123 Worthington Dr.

c. LENGTH OF STAY IN lb

Chevy Chase, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

3. NAME OF
DECEASED
(Type or print)

First Mary Edna Pindell

Middle

Last

4. DATE
OF
DEATH

Sept

12

Day
Year
1958

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

2/27/88

9. AGE (In years
last birthday)70
yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS

Hours
Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Stephens

14. MOTHER'S MAIDEN NAME

Caroline Beecher

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

William Hamilton Pindell same as #2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause first.

(b)

DUE TO

(c)

Acute heart failure

INTERVAL BETWEEN
ONSET AND DEATH

2 hours

Generalized arteriosclerosis

years

Arterosclerotic heart disease

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Has been in chronic failure since Dec. 1956

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. — 19
p. m. —20d. INJURY OCCURRED
While Not while
at work at work20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 26, 1947 to today, 19_____, that I last saw the deceased
alive on 9-12- 1958, and that death occurred at 5:15 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

C P Ryland

M.D.

C P. RYLAND, M.D.
#100-49th St., N. W.
Washington 16, D. C.

9-12-58

PHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

9/12/58

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Baltimore, Md.

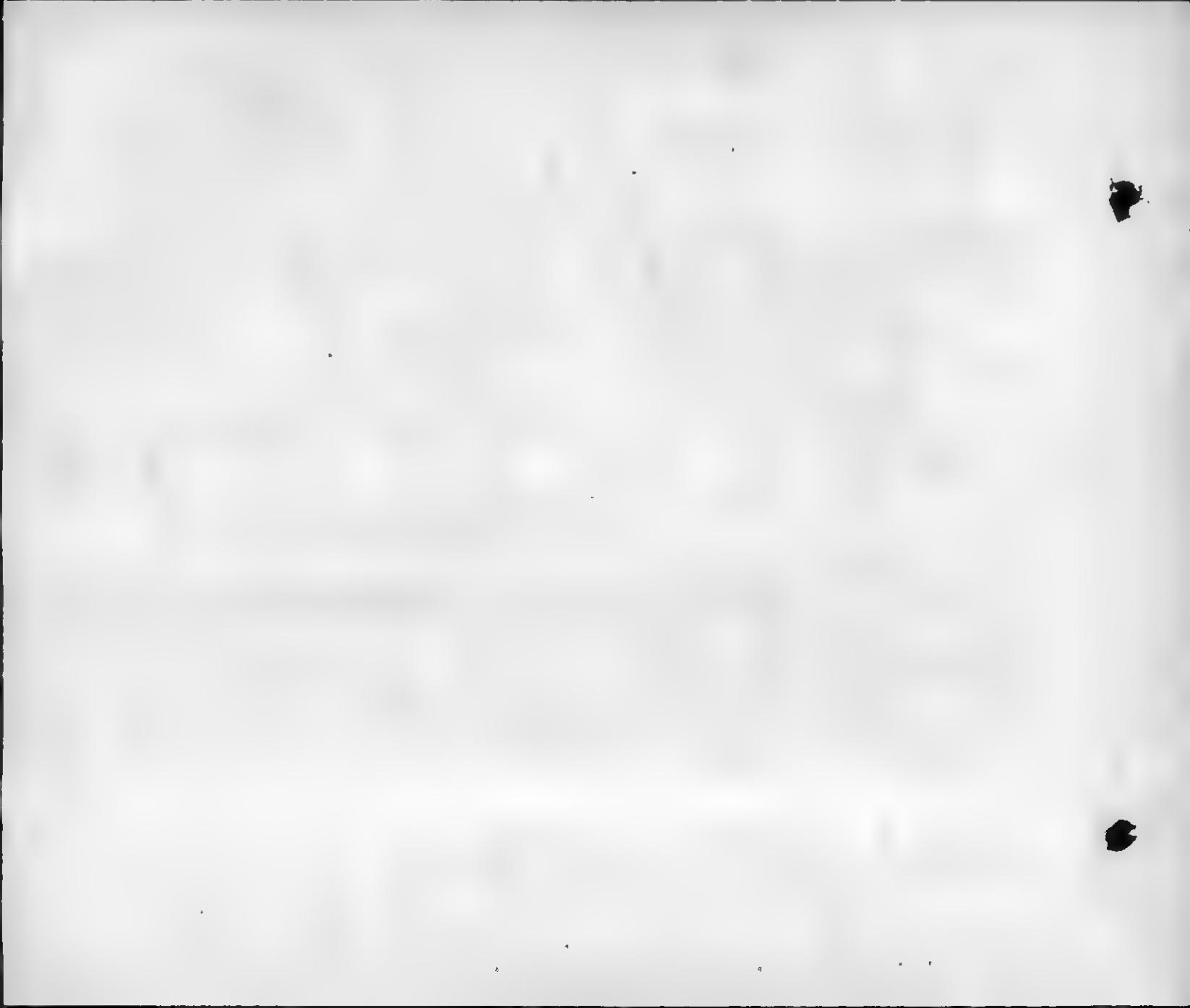
23. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co. Washington 9, D.C.

24a. REC'D BY REGISTRAR
DATE SEP 15 58

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline



10386

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of her death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1 PLACE OF DEATH a. COUNTY		10406		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
Montgomery		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		b. COUNTY Montgomery	
Bethesda		D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				X Boyds	
Suburban Hospital				d. STREET ADDRESS Bucklarge Rd.	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Phyllis		Victoria	Plummer	September 4	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)
Female		Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	X Oct 7 - 57	IF UNDER 1 YEAR yrs Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Carroll William Plummer		Della Virginia Simms Nella V. Plummer - Boyds, Md		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Sudden			
4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Sudden			
(b) DUE TO		Sudden			
(c) DUE TO		Sudden			
Massive Hemoptysis, Bilateral Aspiration Gastric Contents Intestinal Pneumonia					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED 9-4-58			
ACTUAL SIGNATURE: <i>Frank J. Broxhart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type): <i>Frank J. Broxhart</i>					
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-6-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Marks</i>	
				22d. LOCATION (City, town, or county) <i>Bryd, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden Rockville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>SE 9-58 '58</i> DATE <i>8 SEP 9 58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Robert L. Snowden</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10407

CERTIFICATE OF DEATH

10387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd R.F.D		c. LENGTH OF STAY IN 1b 2 dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson R.F.D # 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Susan	Middle Elizabeth	Last Poston	4. DATE OF DEATH Sept 13	Month Sept	Day 13	Year 58
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27-1872	9. AGE (In years 86 b'birthday) yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia		
12. CITIZEN OF WHAT COUNTRY: U.S								

13. FATHER'S NAME John Poston	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs Phyllis Ningrad, 3109-Parkway, Baltimore, Md	Address

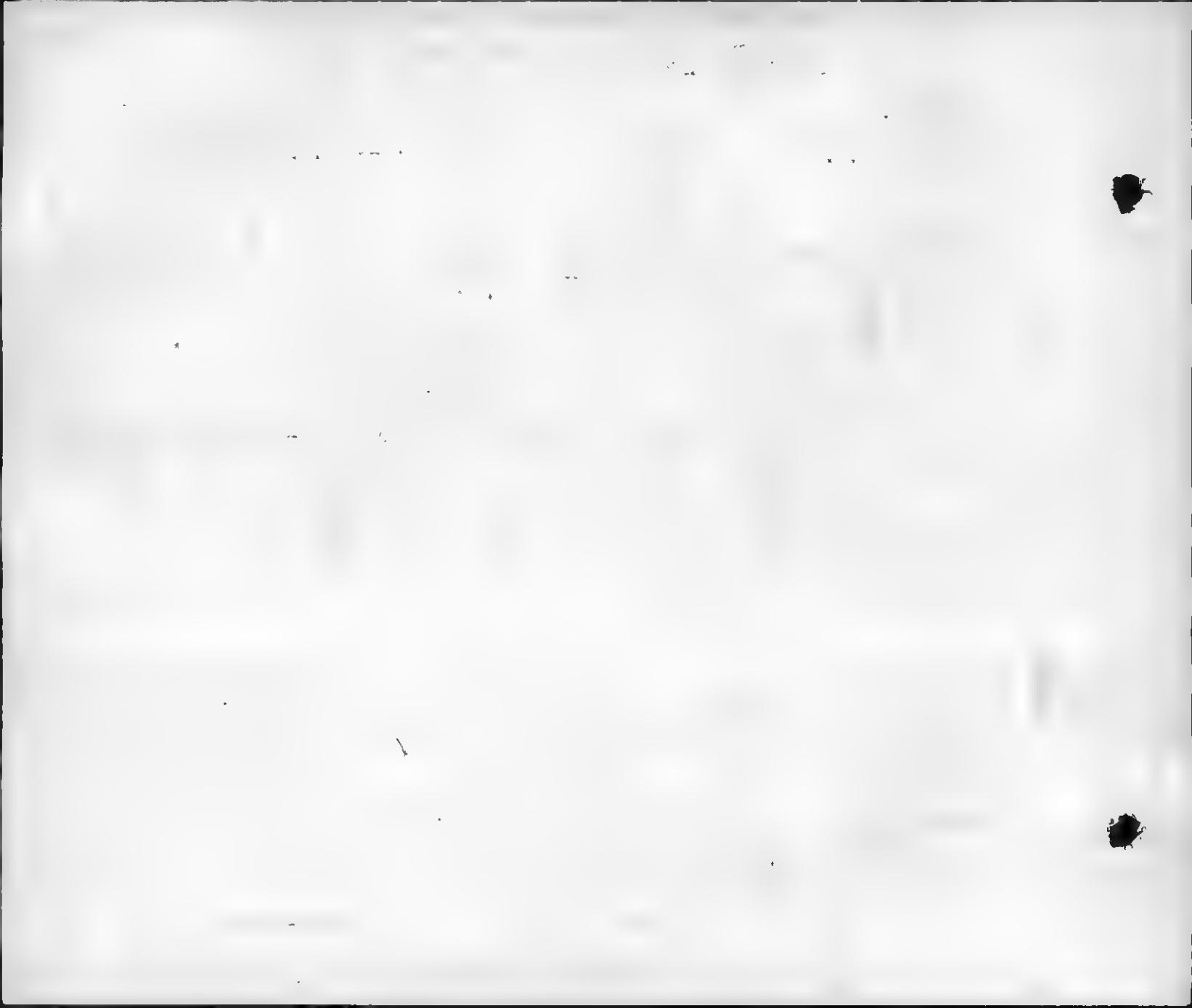
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure		
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Arteriosclerotic Heart + Disease (c) Generalized Arteriosclerosis		2 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June , 1957, to 13 Sept , 1958, that I last saw the deceased alive on 12 Sept , 1958, and that death occurred at 6 A.M. from the causes and on the date stated above			
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ADDRESS (Street, city or town, state)
BARNESVILLE, MD DATE SIGNED
14 Sept 58

ACTUAL SIGNATURE <i>Gordon M. Smith</i>	PHYSICIAN'S NAME (Type) Gordon M. Smith	22a. BURIAL, CREMATON, REMOVAL (Specify) Burial	22b. DATE THEREOF 16 Sept 58	22c. NAME OF CEMETERY OR CREMATORIUM Greenville	22d. LOCATION (City, town, or county) Berryville, Va.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Constance Coffilton Barnesville, Md.		ADDRESS Barnesville, Md.	24a. REC'D BY REGISTRAR SEP 16 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10408

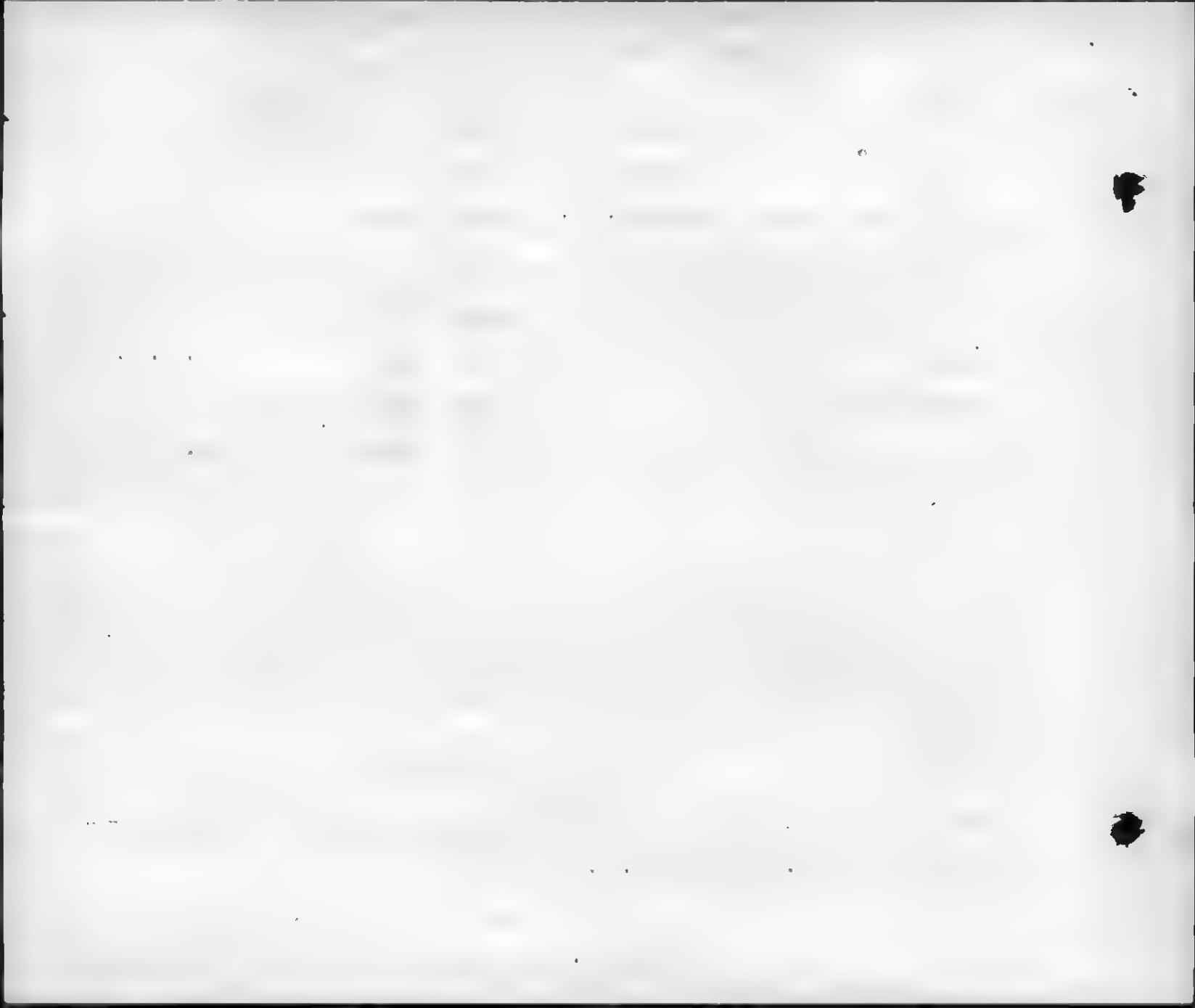
CERTIFICATE OF DEATH

Reg. Dist. No.

10388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia		b. COUNTY Tazewell			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 119 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Amonate		d. STREET ADDRESS (none)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eddie Dean Powers		First	Middle	Last	4. DATE OF DEATH September 1, 1958	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1955	9. AGE (in years lost birthday) 2 yrs	IF UNDER 1 YEAR Months 4	Days 21	IF UNDER 24 HRS Hours 11	Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charlie Powers				14. MOTHER'S MAIDEN NAME Lodina Beavers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 104.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1191		DUE TO purulent meningitis		INTERVAL BETWEEN ONSET AND DEATH hours today					
(b) DUE TO Acute lymphocytic Leukemia						17 mos.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) bronchopneumonia; gastrointestinal hemorrhage							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Amonate		(County) Virginia	(State) 1958
21. I certify that I attended the deceased from May 5, 1958 , to September 1, 1958 , that I last saw the deceased alive on September 1, 1958 , and that death occurred at 12:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-1-58									
ACTUAL SIGNATURE Harold R. Silberman		M.D. The National Institutes of Health Bethesda 14, Maryland							
PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/2/58		22c. NAME OF CEMETERY OR CREMATORIUM Powers Cemetery		22d. LOCATION (City, town, or county) Amonate, Virginia		(State) 1958	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10389

10409

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE West Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 45 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencer		d. STREET ADDRESS 113 Cross Street, Box 224		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Carol	Middle Jean	Lost Propps	4. DATE OF DEATH September 21, 1958	Month September	Day 21	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH June 20, 1945	9. AGE (In years lost birthday) 13 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Ernest L. Propps		14. MOTHER'S MAIDEN NAME Irma Engel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		acute lymphocytic leukemia		INTERVAL BETWEEN ONSET AND DEATH 15 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from August 7, 1958, to September 21, 1958, that I last saw the deceased alive on September 21, 1958, and that death occurred at 1:55 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 9/21/58		
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James M. Marsh, M.D.		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 1400 Chapin St. N.W. Washington		22d. LOCATION (City, town, or county) Spencer W.Va.		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 1400 Chapin St. N.W. Washington		24. REC'D BY REGISTRAR SEP 24 '58 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10410 CERTIFICATE OF DEATH

Reg. Dist. No.

10398

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE Md.		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weaton Silver Spring		c. LENGTH OF STAY IN 1b 3 1/2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weaton, Silver Spring		d. STREET ADDRESS 12013 Grandview Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12013 Grandview Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Rauline		First Rao	Middle Puglisi	Loss Sept	4. DATE OF DEATH 15	Month 1958	Day 15	Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 14, 1899	9. AGE (In years from birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furrier		10b. KIND OF BUSINESS OR INDUSTRY Furs		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Lorenzo Rao			14. MOTHER'S MAIDEN NAME Grace Puglisi					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-18-4588		17. INFORMANT Pasquale Puglisi		Address 12013 Grandview Ave., Silver Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor - Metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral carcinoma of the breast DUE TO (c) 8 years			INTERVAL BETWEEN ONSET AND DEATH 2 months					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 20f (City or town) (County) (State)					
21. I certify that I attended the deceased from Nov. 1950, 19 , to Sept 14, 1958 , that I last saw the deceased alive on Sept 14, 1958 , and that death occurred at 3:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2100 Conn. Ave., N.W., Wash. D.C.								
ACTUAL SIGNATURE Eugene A. PORGIONE		DATE SIGNED 9/15/58						
PHYSICIAN'S NAME (Type) EUGENE A. PORGIONE								
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT 9/18/58		22b. DATE THEREOF 9/18/58	22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN MAUSOLEUM		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 18 58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

10391

10411

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

SILVER SPRING

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

8434 GEORGIA AVENUE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SILVER SPRING

d. STREET ADDRESS

1600 EAST WEST HIGHWAY

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
SEPTEMBER 7

Year
1958

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

62 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS

Hours Min

MALE

WHITE

WIDOWED

DIVORCED

FEB. 14, 1896

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

funeral director

funeral

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

WILLIAM REUBEN PUMPHREY

14. MOTHER'S MAIDEN NAME

HARRIET A. Shekell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

YES WW #1

218-24-3291

Edna C. Pumphrey, 1600 East-West Highway, SS., Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY

Month, Day, Year

Hour

o. m.

p. m.

While

of work

Not while

of work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Frank J. Broschart

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

Sept. 7, 1958

22a. BURIAL, CREMATION, OR REMOVAL (Specify)
BURIAL

22b. DATE THEREOF
9/10/58

22c. NAME OF CEMETERY OR CREMATORIUM
ARLINGTON NATIONAL CEMETERY

22d. LOCATION (City, town, or county)
ARLINGTON, VIRGINIA (State)

22e. FUNERAL DIRECTOR'S SIGNATURE

Raymond J. Gisca

ADDRESS
SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

SEP 9 1958

DATE

24b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A158
BM 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

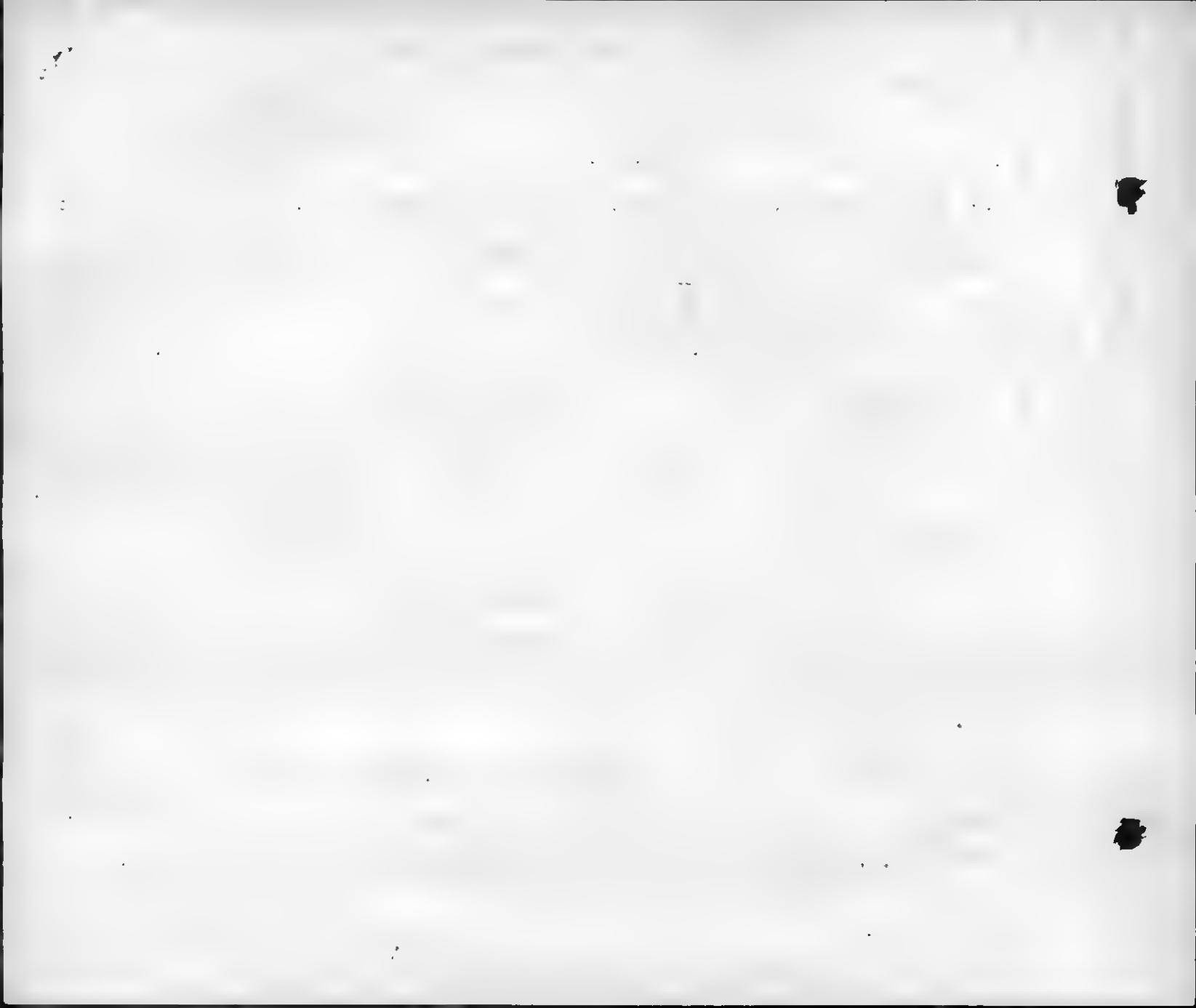
10412

CERTIFICATE OF DEATH

Reg. Dist. No.

10392
215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 mos. 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 87 College Ave.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Walter	Middle Emil	Last QUENSTEDT	4. DATE OF DEATH September	Month	Day 10	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 9 March 1890	9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 8	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Qunstedt		14. MOTHER'S MAIDEN NAME Alberta Crouse					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW-I		17. INFORMANT (Wife) Mrs. May L. Quenstedt (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		Carcinoma of the Lung with Metastases		INTERVAL BETWEEN ONSET AND DEATH About 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 June 19 58 , to 10 Sept. 19 58 , that I last saw the deceased alive on 10 Sept. 19 58 , and that death occurred at 12:55PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>C. U. Shilling</i>		M.D.		U.S. Naval Hospital, Bethesda, Md. 9-10-58			
PHYSICIAN'S NAME (Type) C.U. SHILLING, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-58		22c. NAME OF CEMETERY OR CREMATORIUM Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.M. Taylor</i>		ADDRESS 147 Gloucester St. Annapolis, Md.		24a. REC'D BY REGISTRAR SEP 19 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Knauk</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS ATSM
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10413

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>	b. COUNTY <i>Md</i>		
c. LENGTH OF STAY IN 1b <i>D.O.A.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookville</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Montgomery Gen Hospital</i>	d. STREET ADDRESS <i>Community Rd.</i>		
3. NAME OF DECEASED (Type or print) <i>Ralph A. Reece</i>	4. DATE OF DEATH Year <i>Sept 23 1958</i>		
First <i>Ralph</i>	Month <i>Sept</i>		
Middle <i>A.</i>	Day <i>23</i>		
Last <i>Reece</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Nov 9 1934</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Gas station</i>	11. BIRTHPLACE (State or foreign country) <i>Tenn.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Violetta Reece</i>	14. MOTHER'S MAIDEN NAME <i>Nancy McDaniels</i>	Address <i>Estella Reece R-2 Gaithersburg Md</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Name, no. or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>unknown</i>	17. INFORMANT <i>Estella Reece R-2 Gaithersburg Md</i>	18. INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i>			
823X DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. DUE TO <i>decerebration</i>			
(c) <i>Auto accident</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Was driving car that crossed bridge & overturned in Puttent R.</i>			
20c. TIME OF INJURY Hour <i>5:30 p.m.</i>	Month, Day, Year <i>9-1 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Md R-77</i>
20f. (City or Town) <i>Md</i>	(County) <i>Montgomery</i>	(State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <i>9-1-58</i>	
EXAMINER'S NAME (Type) <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CRETATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/4/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Liberty Baptist</i>	22d. LOCATION (City, town, or county) <i>Lisbon, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne Barber</i>		ADDRESS <i>Laytonsville, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 5 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Walter L. Knapp</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10291

CERTIFICATE OF DEATH

10394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL Takoma Park		c. LENGTH OF STAY IN lb		b. COUNTY	
		259 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Washington 41	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		WASHINGTON SANITARIUM & HOSPITAL		d. STREET ADDRESS		4216 YUMA ST., N.W.	
3. NAME OF DECEASED (Type or print)		First JAMES	Middle DEE	4. DATE OF DEATH	Month SEPTEMBER	Day 29	Year 1958
5. SEX MALE		6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 19-14-00	9. AGE (in years lost birthday) 58 yrs	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS. Days 11 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Information Sp.		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Defense		11. BIRTHPLACE (State or foreign country) Oregon		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME James Green Richardson		14. MOTHER'S MAIDEN NAME Maude Hughes		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chart Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 49% Broncho Pneumonia		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/14</u> , 1958, to <u>September 29</u> , 1958, that I last saw the deceased alive on <u>September 29</u> , 1958, and that death occurred at <u>3:37 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Albert E. Marland, Jr.</u> M.D. 1216 16th St. N.W. Wash. 6, D.C. 9/30/58				ADDRESS (Street, city or town, state)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/2/58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory		22d. LOCATION (City, town, or county) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Thompson</u>		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 2 '58		24b. REGISTRAR'S SIGNATURE J. L. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, it must be given to the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10292

CERTIFICATE OF DEATH

Reg. Dist. No.

10396

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 5½ months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVENUE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) ANNIE		First BURCH	Middle RILEY
4. DATE OF DEATH SEPT. 15 1958	Month Month	Day Day	Year Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 2/11/76
8. IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS Days yr.	Hours hrs.	Min. min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME G. MORTIMER CECIL		14. MOTHER'S MAIDEN NAME SARAH J. BURCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Edgar L. Burch, 711 Orchard Way		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH 9 months.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic heart disease -		(b) 4 years.	
DUE TO Arteriosclerosis & Hypertension -		(c) 7 years.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) PRINCE GEORGE COUNTY, MD.	
21. I certify that I attended the deceased from Sept 13 1958 to Sept 15 1958 , that I last saw the deceased alive on Sept 13 1958 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Neil P. Campbell PHYSICIAN'S NAME (Type) Neil P. Campbell -		ADDRESS (Street, city or town, state) Kensington Apt. DATE SIGNED 9/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/18/58	
22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE SEP 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

10414

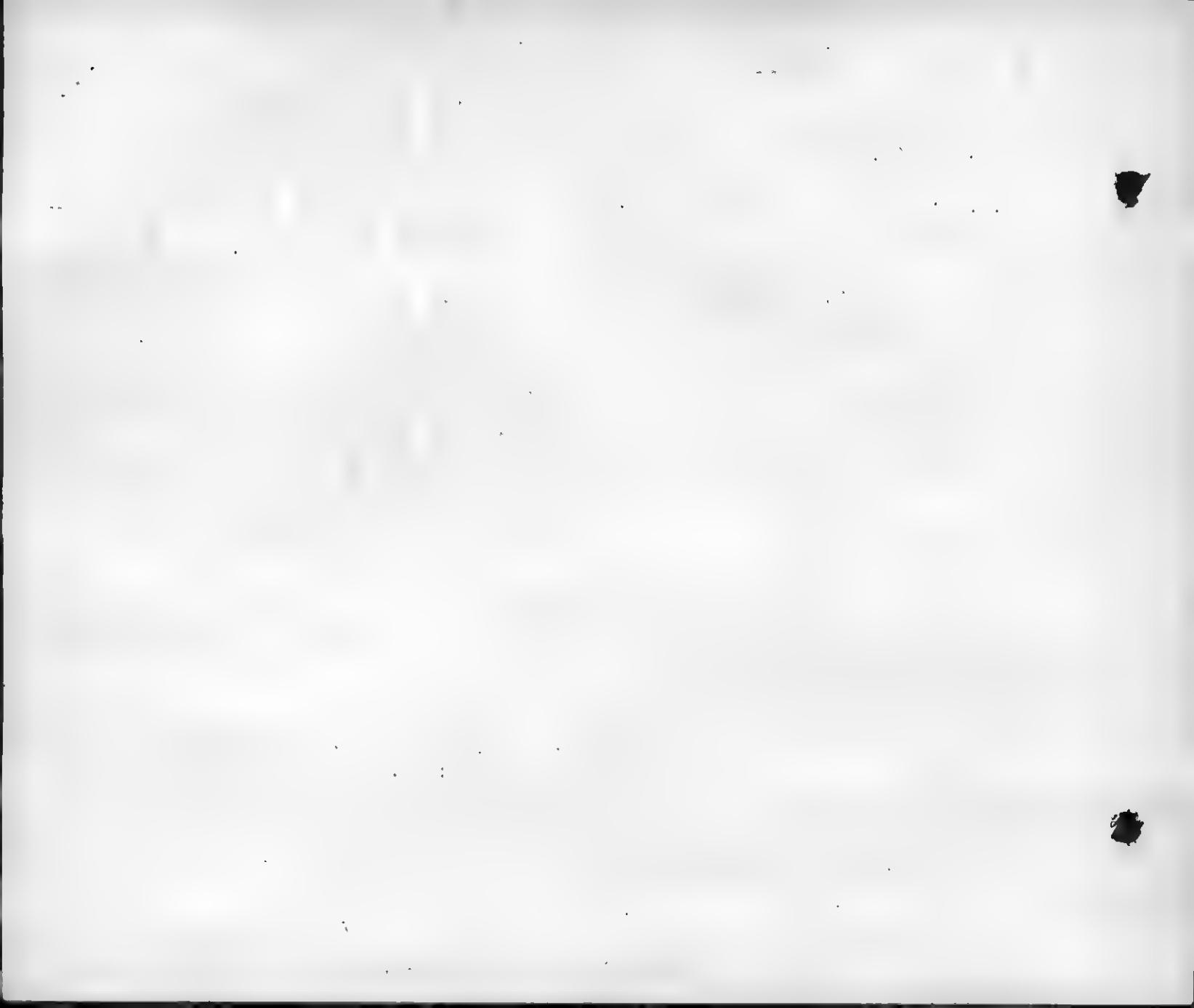
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbolic papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 541 Bellevue Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Donald	Middle Dennis	Last ROSCH	4. DATE OF DEATH	Month Sept.	Day 19	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 13 Sept. 1958	9. AGE (In years from birthday) yrs. 8	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS Days 8	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Leon ROSCH				14. MOTHER'S MAIDEN NAME Jeanne Evelyn MAC LELLAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT (Father) Leon ROSCH (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 759.3 <i>Bactalmia, organism E. coli.</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>multiple congenital anomalies</i> 6 days (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month Sept.	Doy 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Arlington	(State) Virginia
21. I certify that I attended the deceased from 13 Sept. 1958 , to 19 Sept. 1958 , that I last saw the deceased alive on 19 Sept. 1958 , and that death occurred at 11:10A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED De Paola for Dr. Harris							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) F. De PAOLA LT MC USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-23-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l CEMETERY		22d. LOCATION (City, town, or county) Arlington		(State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE H. P. Morris		ADDRESS ARLINGTON Funeral Home 3901 North Fairfax Drive Arlington, Virginia		24a. REC'D BY REGISTRAR SEP 23 '58	24b. REGISTRAR'S SIGNATURE L. J. Marie		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

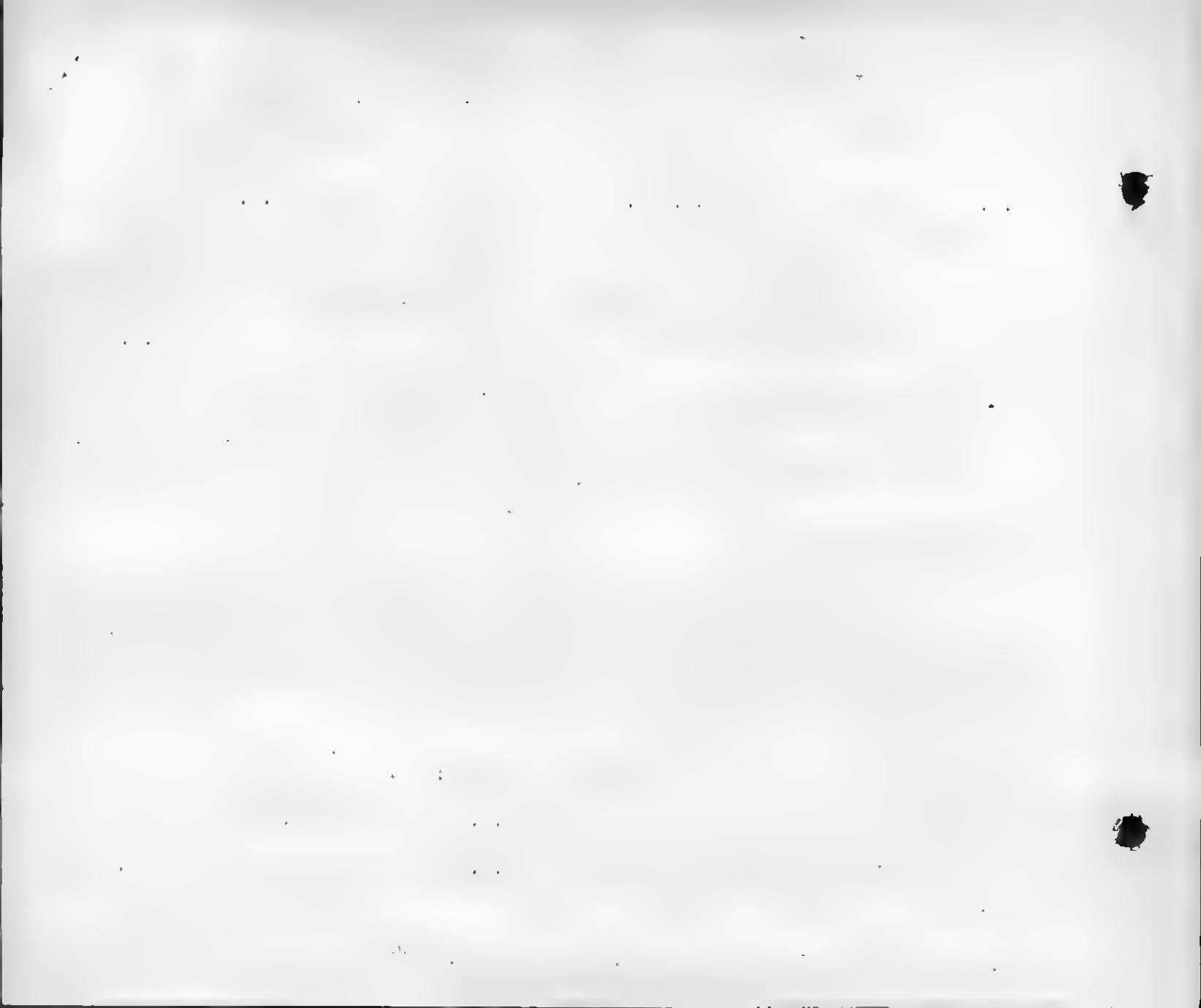
10398
215

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10415

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 19 Days		d. STREET ADDRESS 1606 "W" Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1606 "W" Street, S.E.							
3. NAME OF DECEASED (Type or print) Betty		First Betty	Middle Mae	Last SARGENT	4. DATE OF DEATH September 17 1958	Month September	Day 17	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5 November 1937	9. AGE (In years last birthday) 20 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Johnny Freeman BENTON				14. MOTHER'S MAIDEN NAME Mary Elizabeth LASTER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT (Husband) Richard John SARGENT (Same As #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pyelonephritis with abscess formation and DUE TO papillary necrosis, bilateral									INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 29 August 1958 to 17 Sept. 1958 , that I last saw the deceased alive on 17 Sept. 1958 , and that death occurred at 9:26 P.M. , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.									DATE SIGNED 9-18-58
ACTUAL SIGNATURE <i>C.R. Boyce</i>		M.D.							
PHYSICIAN'S NAME (Type) C.R. BOYCE, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58		22c. NAME OF CEMETERY OR CREMATORIUM Weldon Cemetery		22d. LOCATION (City, town, or county) Weldon, North Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i>		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 23 '58		24b. REGISTRAR'S SIGNATURE <i>Cynthia S. Hansen</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10416 <i>Sten 10/24/14 10/23 46270 903</i>										10399					
CERTIFICATE OF DEATH										Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 42 days					b. COUNTY Prince Georges					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH NNMC Bethesda, Maryland					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville					f. STREET ADDRESS Rockville Pike				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Emma	Middle Elizabeth	Last SCHMULOVITZ	4. DATE OF DEATH September 6 1958		Month September	Day 6	Year 1958						
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 13, 1877		9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home					10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME JOHN F. TALBERT					14. MOTHER'S MAIDEN NAME ANNIE GROENERT					Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 116-33-1234			17. INFORMANT MRS JOSEPHINE GELFO			18. DECEASED ADDRESS 6524 8th Ave Ray Park, Md.						
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH Jul 27, 1958					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Cerebral Vascular Accidents															
33IX DUE TO															
Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause last. (b) Generalized Peripheral Vascular Disease															
DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
Carcinoma, Breast with Metastasis															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)										
20c. TIME OF INJURY Month, Day, Year Hour 6:55 p. m. Sep 6 1958					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USNH, NNMC, Bethesda, Md.		(County) M.D.	(State) Md.		
21. I certify that I attended the deceased from Jul 27, 1958 to Sep 6, 1958 , that I last saw the deceased alive on Sep 6, 1958 , and that death occurred at 1855P , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) USNH, NNMC, Bethesda, Md.		DATE SIGNED Sep 7, 1958			
ACTUAL SIGNATURE <i>W. J. Jacoby Jr.</i>															
PHYSICIAN'S NAME (Type) W. J. JACOBY Jr.										USNH, NNMC, Bethesda, Md.		Sep 7, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sep 7, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL Congressional Wash., D.C.		22d. LOCATION (City, town, or county) Washington, D. C.									
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Talbert</i>		ADDRESS 254 Carroll St NW		24a. REC'D BY REGISTRAR 10 '58		24b. REGISTRAR'S SIGNATURE <i>C. E. L. Kress</i>									



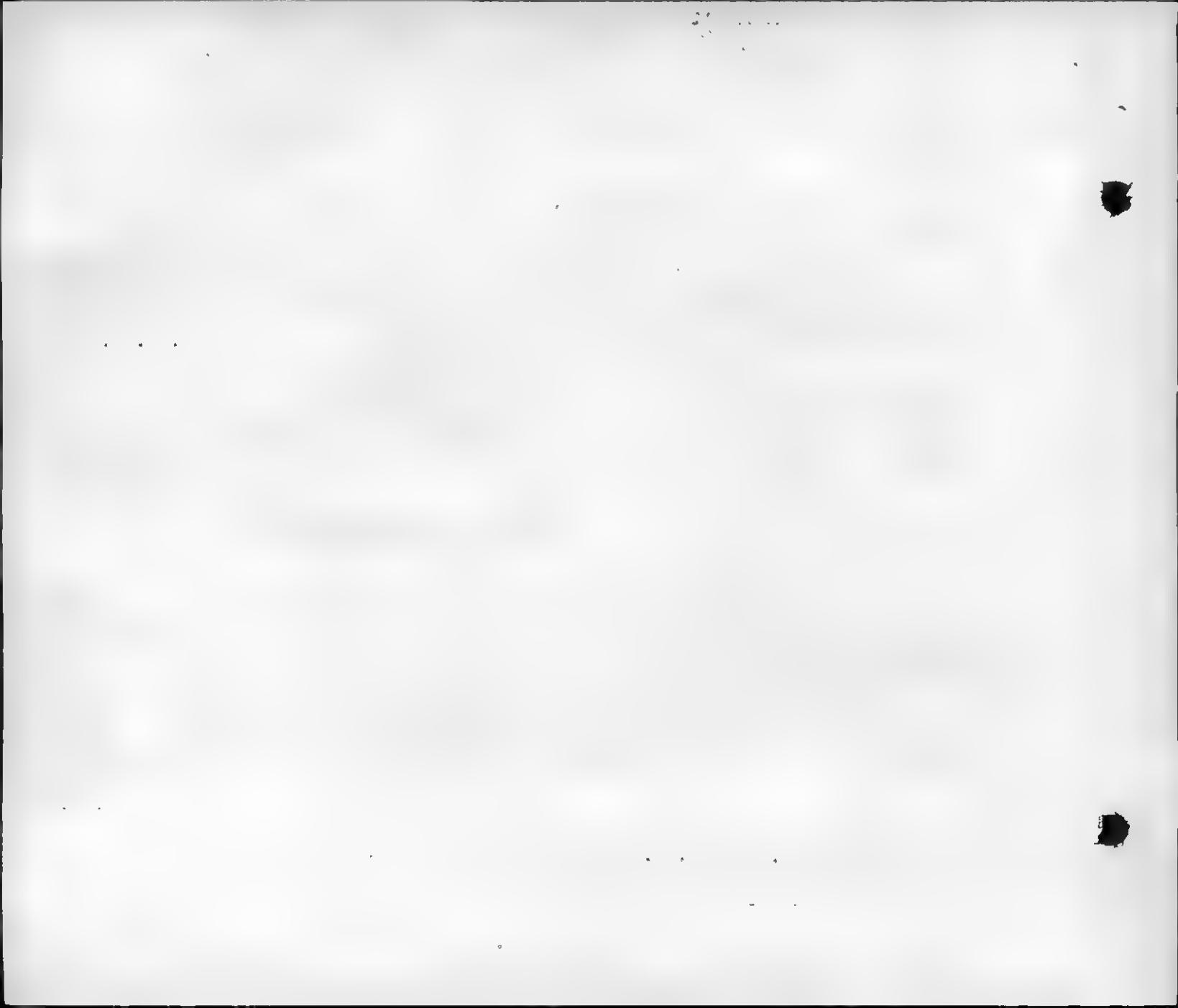
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10409

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Indiana			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 39 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jasper			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 322 East 15th Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edwin	Middle Richard	Last Schutz	4. DATE OF DEATH September 14, 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1919	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Superintendent		10b. KIND OF BUSINESS OR INDUSTRY City Government		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Edward Schutz			14. MOTHER'S MAIDEN NAME Augusta Treterer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WW II		17. INFORMANT The Medical Record Address Unavailable The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO 173X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Choriocarcinoma with pulmonary metastases DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH 4 Weeks						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Metastases to brain, liver, thyroid and pancreas						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from September 14, 1958, and that death occurred at 8:00 A.M.		that I last saw the deceased alive on August 6, 1958, at September 14, 1958, M, from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Richard H. Moy</i>		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland				
PHYSICIAN'S NAME (Type) Richard H. Moy, M. D.		DATE SIGNED 9-14-58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 9-14-58		22b. DATE THEREOF Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Dubois County, Indiana		
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DA SEP 18 '58		
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10418 CERTIFICATE OF DEATH

Reg. Dist. No.

10401

1. PLACE OF DEATH o COUNTY Montgomery				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Alabama							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 days				b. COUNTY							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phenix City							
								d. STREET ADDRESS Route 3, Box 517							
3. NAME OF DECEASED (Type or print)				First Randolph	Middle (none)	Last Scott	4. DATE OF DEATH September 5, 1958	Month September	Day 5	Year 1958	b. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH November 14, 1957		9. AGE (in years from birthday) yrs 9 21		IF UNDER 1 YEAR Months 9 Days 21		IF UNDER 24 HRS Hours 11 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Jacob Scott								14. MOTHER'S MAIDEN NAME Alberta Bell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> [Yes, no, or unknown] <input type="checkbox"/> [If yes, give war or date of service] No				16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital tricuspid arteriosus and</i> INTERVAL BETWEEN ONSET AND DEATH since birth DUE TO <i>intraventricular septal defect</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } 11 hours post op. (b) <i>Cardiac arrest, post operative complications</i> DUE TO hours (c) <i>Shock congestive; lungs, liver, spleen, kidneys</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from August 24, 1958, to September 5, 1958, that I last saw the deceased alive on September 5, 1958, and that death occurred at 11:20 P.M., from the causes and on the date stated above.												ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>Robert S. Bloominell</i>												DATE SIGNED 9/7/58			
PHYSICIAN'S NAME (Type)				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9/11/58		22c. NAME OF CEMETERY OR CREMATORIAL DE				22d. LOCATION (City, town, or county) Columbus, Ga.				(Note)			
23a. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson & Jenkins Funeral Home</i>				ADDRESS 4804 Ga. Avenue				24a. REC'D BY REGISTRAR SEP 15 '58				24b. REGISTRAR'S SIGNATURE <i>Albert S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician;
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



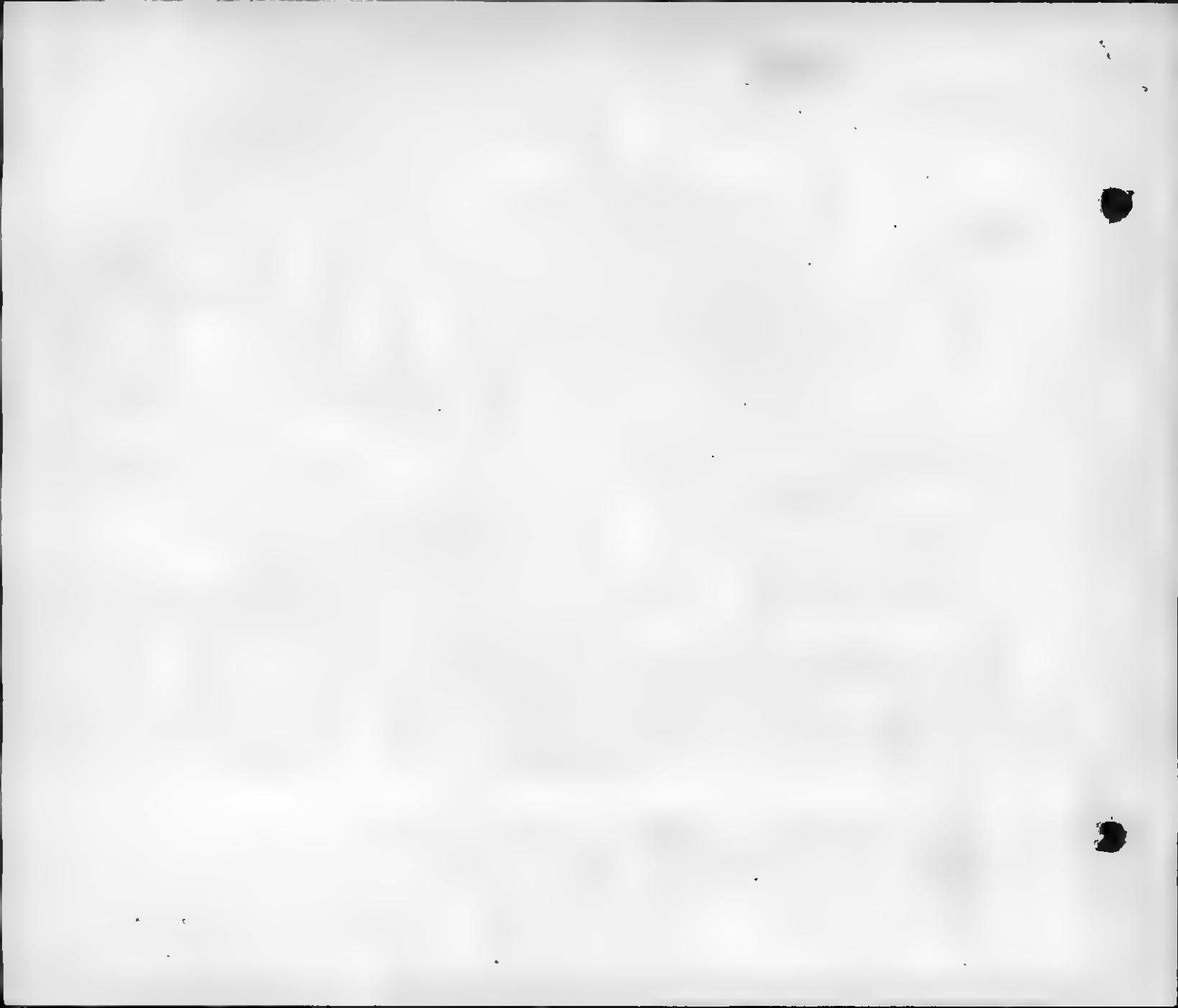
1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10402

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

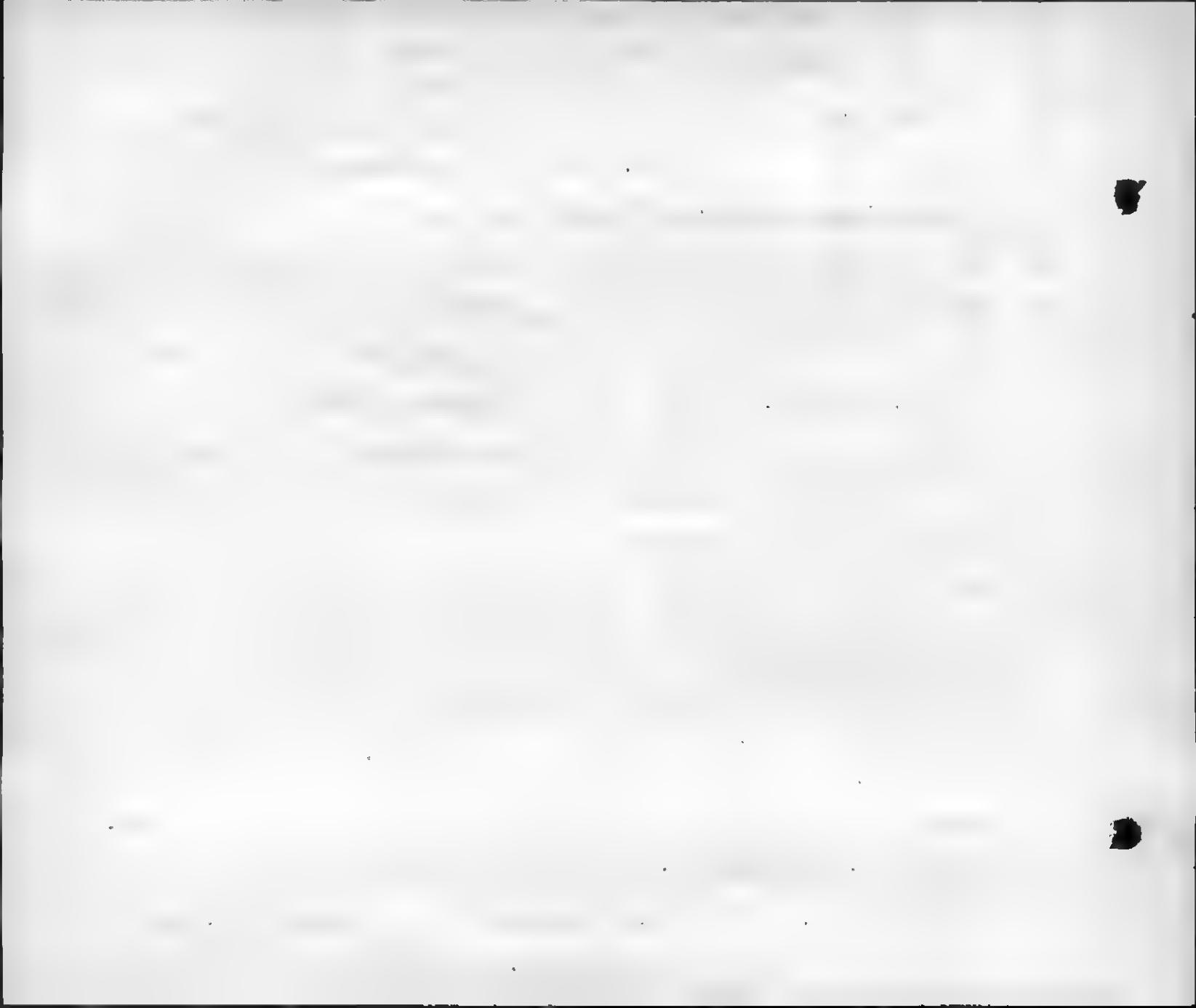
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Reg. Dist. No.	
<i>Montgomery</i> <i>MARYLAND</i>		<i>Md</i> <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<i>Rockville</i>	<i>6 1/20</i>	<i>Roslyn</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>12917 Parkland Dr.</i>		<i>12917 Parkland Dr.</i>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
<i>Antonino</i>		<i>Scuderi</i>		<i>Sept 24</i>	<i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	9. AGE (in years last birthday)		
<i>Male</i>	<i>White</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 2-1-94</i>	<i>67 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>R.R. car repairman</i>		<i>retired</i>	<i>Italy</i>		<i>U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address	
<i>Scarmela Scuderi</i>		<i>Rose</i>		<i>Itur 2</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH	
<i>No</i>		<i>718-14-9114</i>	<i>Rose Scuderi</i>	<i>5 days</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) if none, /		Acute myocarditis			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Chronic Cardio-Vascular disease			
(b) DUE TO (c)		12 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED			
ACTUAL SIGNATURE	<i>Frank J. Borschart</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)	<i>Frank J. Borschart</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/27/58	22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery	22d. LOCAT ON (City, town, or county) Montgomery County, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond J. Borska, Silver Spring, Md.	ADDRESS	24a. REC'D BY REGISTRAR SEP 26 '58	24b. REGISTRAR'S SIGNATURE C. H. 8 Hause		
VS ALIVE 6M 2/57					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
10419 CERTIFICATE OF DEATH 10403 Reg. Dist-No.									
1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Howard						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 63 hrs. 23 min.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Baby		First	Middle	Last	4. DATE OF DEATH Selby	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/58	9. AGE (In years lost birthday) yrs 63	IF UNDER 1 YEAR IF UNDER 24 HRS Months 63	Days 23	Hours Min 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME John E. Selby, Sr.			14. MOTHER'S MAIDEN NAME Hilda M. Affeldt						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address Olney, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH 2 days									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 3, 1958 , to Sept. 5, 1958 that I last saw the deceased alive on Sept. 5, 1958 , and that death occurred at 2:40 AM , from the causes and on the date stated above									
ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED Sept. 5, 1958									
ACTUAL SIGNATURE C. S. Whitaker, M. D.									
PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5, 1958		22d. LOCATION (City, town, or county) Ellicott City, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons		ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 File No. 921582

CERTIFICATE OF DEATH

Reg. Dist. No.

10404

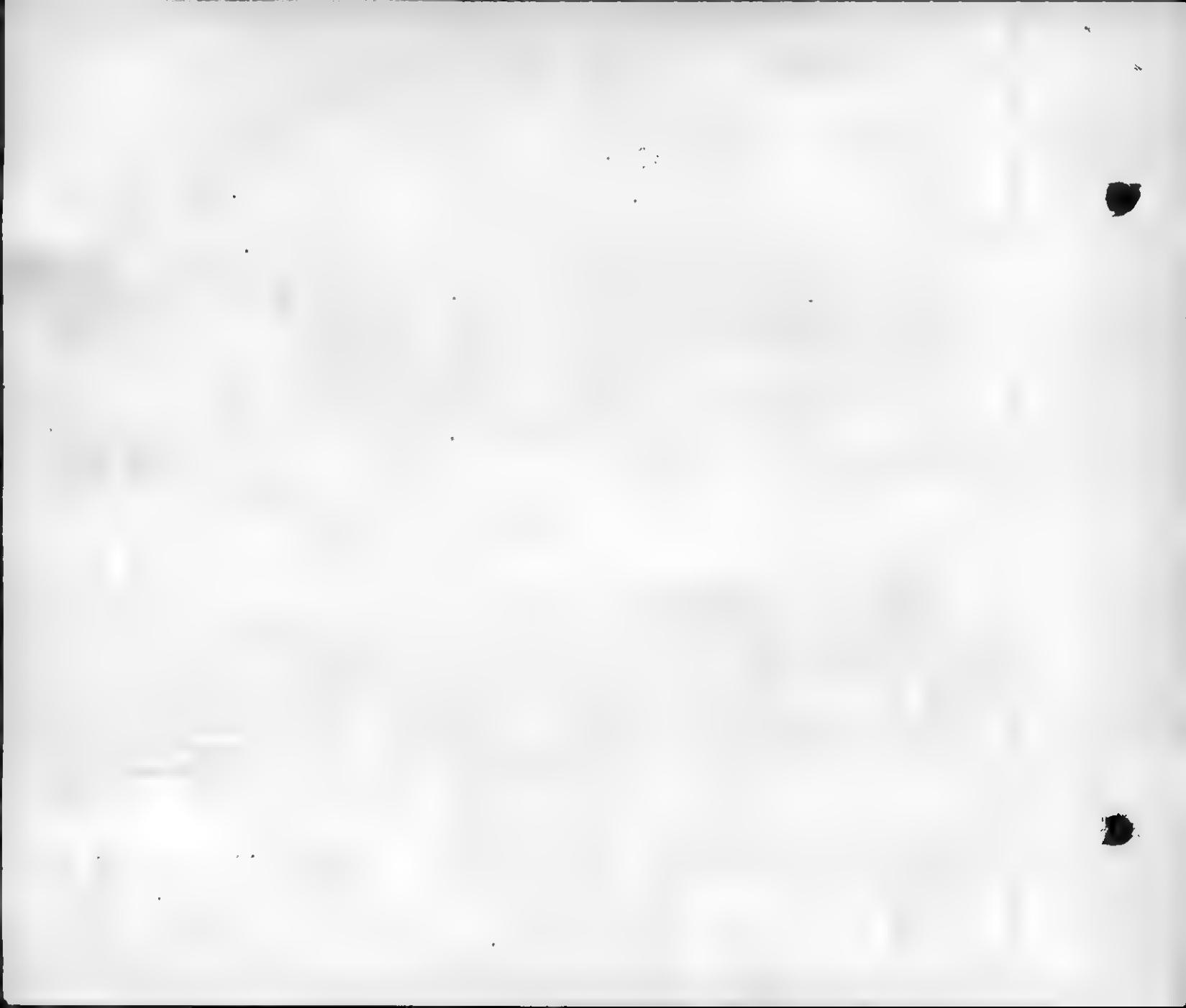
10420

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 15 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5620 Southwick St.	d. STREET ADDRESS 5620 Southwick St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRA S. SHANTZ	First	Middle	Last	
4. DATE OF DEATH Sept. 11, 1958	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1879	
9. AGE (In years last b'day) 78 yrs.		10. IF UNDER 1 YEAR Months 11 Days 29 Hours 0 Min.	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Printing		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Baden, Ontario, Canada	
12. CITIZEN OF WHAT COUNTRY? United States				
13. FATHER'S NAME Christian Shantz		14. MOTHER'S MAIDEN NAME Nancy Steiner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 578-05-4069	17. INFORMANT (Wife) Gladys B. Shantz	
		Address Same as Item 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 5 minutes				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerosis generalized				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 11, 1958, to Sept. 11, 1958, that I last saw the deceased alive on Sept. 11, 1958, and that death occurred at 12 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Alfred S. Norton M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 9-12-58		
PHYSICIAN'S NAME (Type) ALFRED S. NORTON		4711 Highland Ave., Bethesda, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-13-58	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Prince George Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR SEP 16 58	24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10405

10421 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenelg</u>		c. LENGTH OF STAY IN 1b <u>50 days</u>		o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove foundation</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>3229 Medway St.</u>	
3. NAME OF DECEASED (Type or print) <u>Petta Marguerite Shaw</u>		First	Middle	Last	4. DATE OF DEATH <u>Sept 9 1958</u>
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>May 31 1884</u>	9. AGE (in years lost birthday) <u>74 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		Address			
13. FATHER'S NAME <u>XOXXOXX XOX</u>		14. MOTHER'S MAIDEN NAME <u>Henriette</u>		unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Jean Karrie 3229 Medway St. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular Accident</u> DUE TO <u>33IX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>9 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 Sept</u> , 19 <u>58</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Morris Perry</u> PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/12/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>PAKKLAWN CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>MONTGOMERY COUNTY, MARYLAND</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond S. Jiska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arnold S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10406

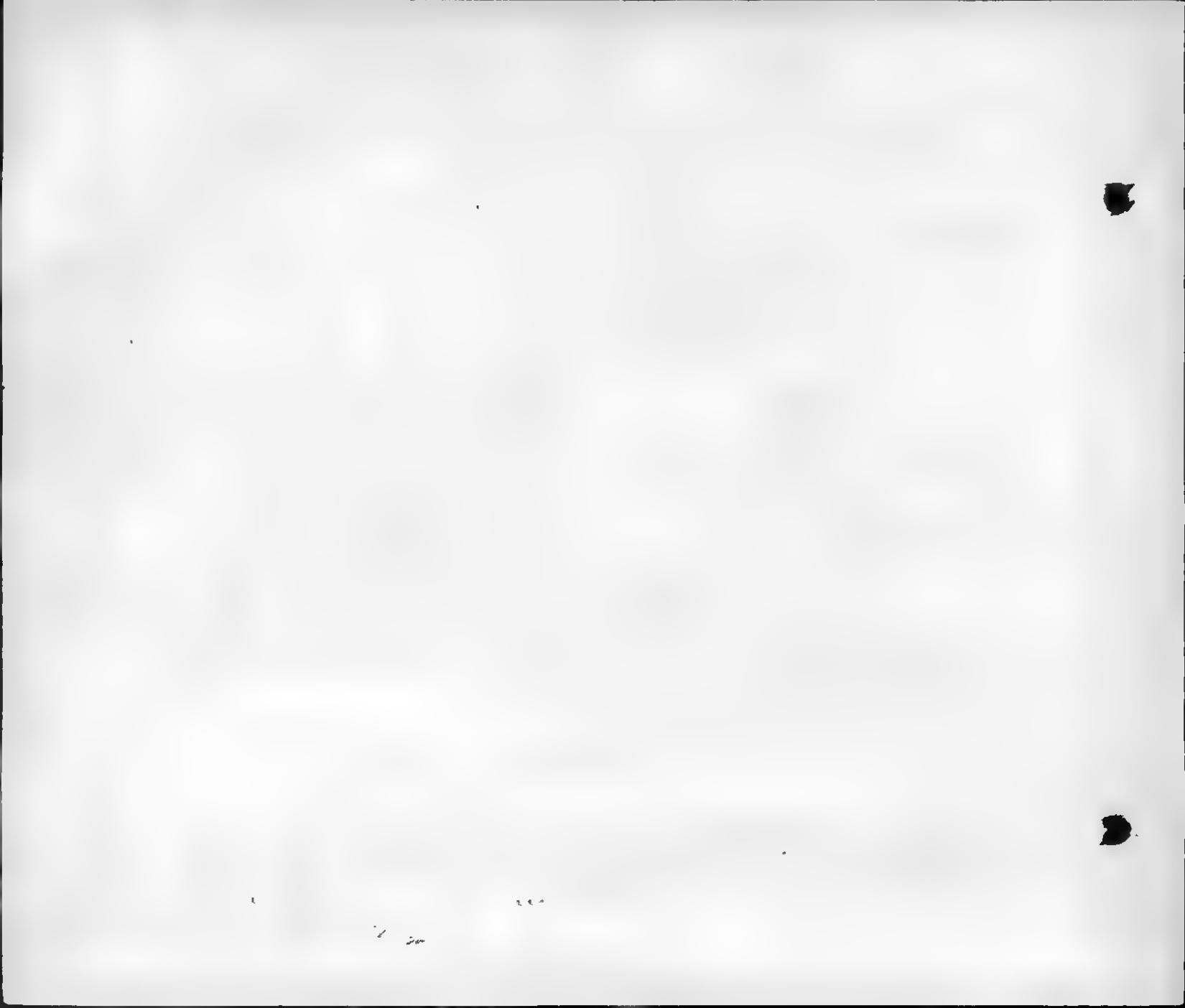
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c LENGTH OF STAY IN 1b 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 606 No. Horner's Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Henry	Middle Francis	Last Shelton
4. DATE OF DEATH	Month September	Day 21	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1911
9. AGE (In years less birthday) 40 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Naval Medical Center	
10c. BIRTHPLACE (State or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Shelton		14. MOTHER'S MAIDEN NAME Maggie Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Lucinda Sheldon	
17. INFORMANT Wife		Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost! (b) DUE TO Hemorrhage Arteriosclerosis (c) Hypertension w/o disease		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1-2 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1958, to 9/21, 1958, that I last saw the deceased alive on 7/21, 1958, and that death occurred at 3:05 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Stephen N. Jones M.D. Rockville, Md. DATE SIGNED 7/21/58			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/58	
22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Park,		22d. LOCATION (City, town, or county) Rockville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Snowden, Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 24 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Knott	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10423

CERTIFICATE OF DEATH

Reg. Dist. No.

10407

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY			
c. LENGTH OF STAY IN lb RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9200 Old Georgetown Rd.		d. STREET ADDRESS Dodge Hotel			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Lyle	Middle Gordon	Last Shuck, Sr.		
4. DATE OF DEATH	Month SEP	Day 13	Year 1958		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1895		
9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt Print. Office	10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	11. BIRTHPLACE (State or foreign country) Grafton, W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Walter Shuck	14. MOTHER'S MAIDEN NAME Minerva E. Sieff	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Ildda J. Shuck. (wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH ONE YR?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Metastatic SARCOMATOSIS PRIMARY SITE UNDETERMINED			
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 8025 Aberdeen Rd	20f. (City or town) Bethesda	(County) Md.	(State) Md.
21. I certify that I attended the deceased from _____, 1947, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE DeWitt E. DeLawter M.D. ADDRESS (Street, city or town, state) 8025 Aberdeen Rd DATE SIGNED 7/10/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Sept. 13, 1958 - Lees Crematorium	22c. NAME OF CEMETERY OR CREMATORIUM Lees Crematorium	22d. LOCATION (City, town, or county) Washington D.C.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. DeLoach		ADDRESS 300 1/2 St N.E.	24a. REC'D BY REGISTRAR DATE SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



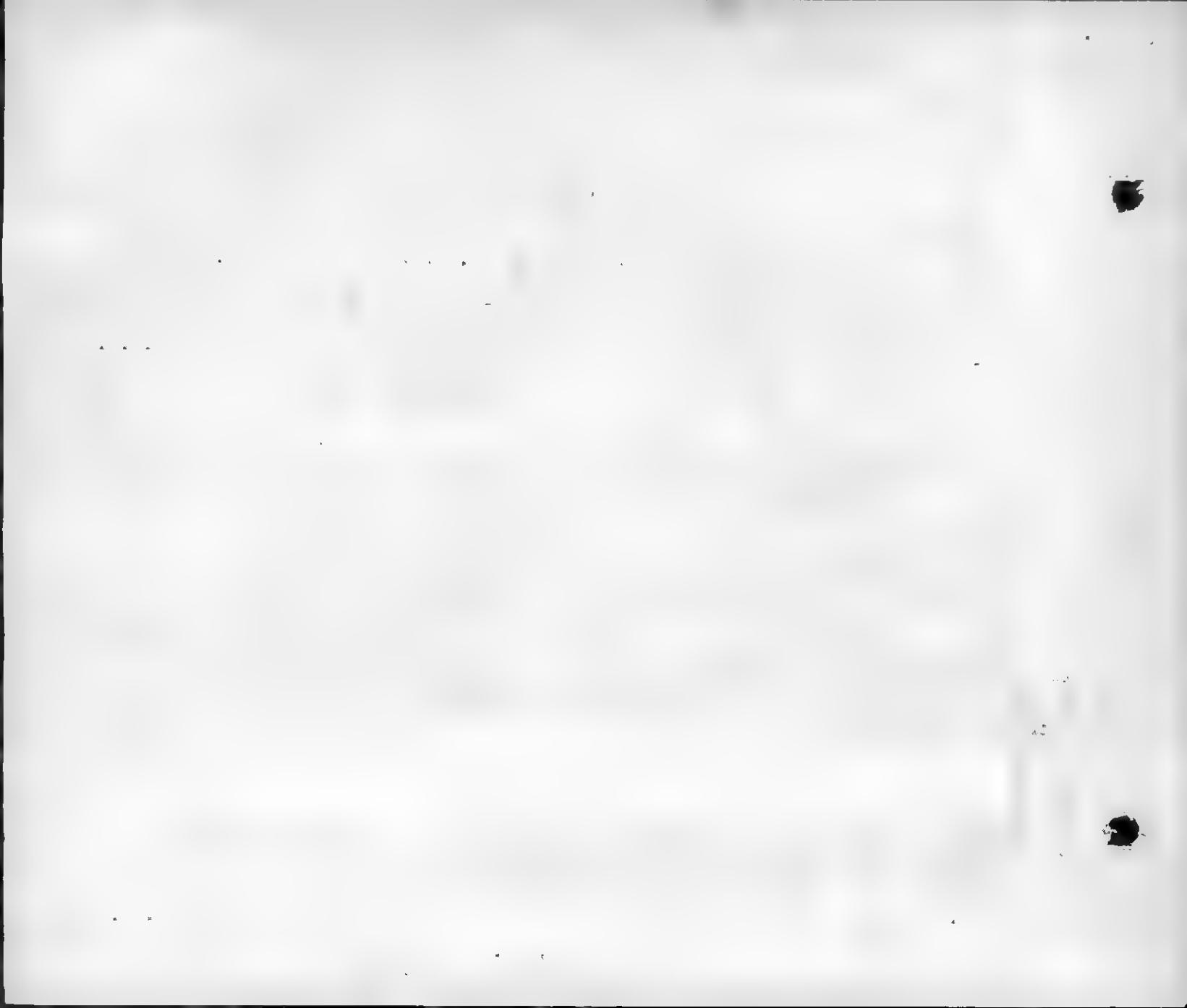
K-1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be returned to your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10408
 10524 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY NO TIGON RY		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 703 Dale Drive		e. STREET ADDRESS 703 Dale Drive	
f. IS RESID F ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louise		First Wetherill	Middle Slack, M.D.
4. DATE OF DEATH Sept. 8 1958		5. SEX female	6. COLOR OR RACE white
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-30-1908	
9. AGE (in years last birthday) 49		10. IF UNDER 18 YEARS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Slack		14. MOTHER'S MAIDEN NAME Maud Wetherall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. yes	
17. INFORMANT John B. Slack, III - 703 Dale Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Found Dead on bedroom floor of house	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <i>9-8-58</i>	
EXAMINER'S NAME (Type) FRANK J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL/CREMATION/REMOVAL (Specify) Trans. & Burial		22b. DATE THEREOF 9/11/58	
22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Burlington County, N. J.	
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>		24a. REC'D BY REGISTRAR DATE SEP 10 '58	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Lewis</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10425

CERTIFICATE OF DEATH

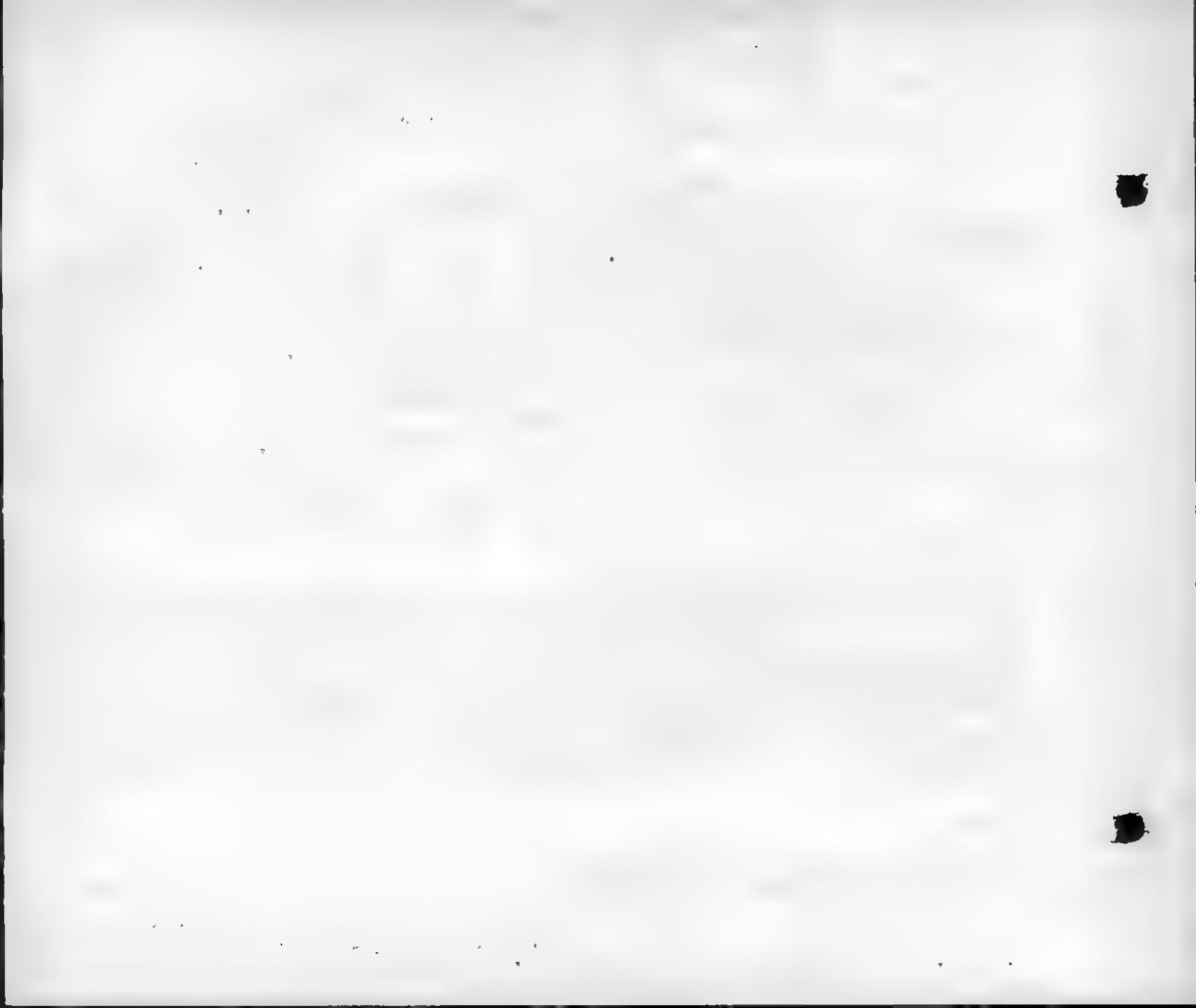
Reg. Dist. No.

10409

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Batchellor's Forest Road, Olney	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Nursing Home		d. STREET ADDRESS XXXXXX	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHANNA	Middle H.	Last SLYE
4. DATE OF DEATH	Month Sept.	Day 22	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1869
9. AGE (In years last birthday) 89 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Address Home Records - Olney, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Infarctus</i> — Far advanced DUE TO (c) <i>arteriosclerotic Cardia Vasculitis</i> INTERVAL BETWEEN ONSET AND DEATH 3 days 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw the deceased alive on _____ 21 Sept 1958 and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John B. Ziegler</i> M.D. ADDRESS (Street, city or town, state) <i>OLNEY, MD</i> DATE SIGNED <i>22 Sept 58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/58	22c. NAME OF CEMETERY OR CREMATORIUM Congressional Cemetery Washington, D.C.
22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		ADDRESS Wash. D.C.	24a. REC'D BY REGISTRAR DATE SEP 24 '58
		24b. REGISTRAR'S SIGNATURE <i>C. Ruth S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10426

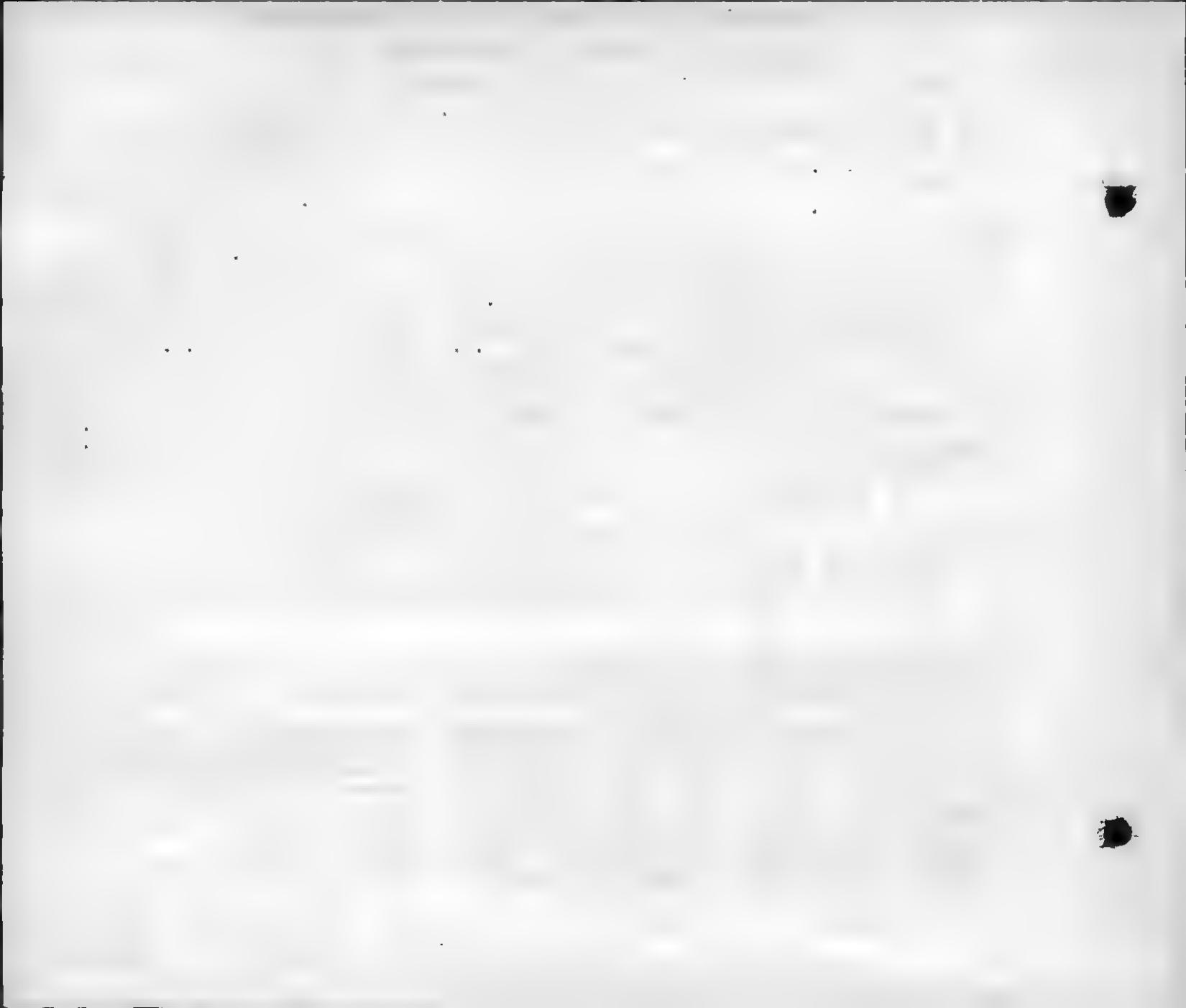
CERTIFICATE OF DEATH

Reg. Dist. No. 410

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clermont</u>		d. STREET ADDRESS <u>1317 Carter St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4327 Carter St.</u>				d. STREET ADDRESS <u>1317 Carter St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eben Smith Wright</u>		First <u>Eben</u>	Middle <u>Smith</u>	Last <u>Wright</u>	4. DATE OF DEATH <u>Sept. 14, 1952</u>	Month <u>Sept.</u>	Day <u>14</u>	Year <u>1952</u>	
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1875</u>	9. AGE (in years lost birthday) <u>77 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 24 HRS. Days <u>0</u>	Hours <u>0</u>	Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Life</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Eben Smith Wright</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Hulbert</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Miss Mildred Kathryn Smith, his wife,</u>		Address <u>3921 71st Street, N.W., Wash. 15, D.C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<u>Cerebral Thromboses, multiple</u> <u>5 days</u>							
(b) DUE TO Arteriosclerosis, general, severe		<u>12 yrs.</u>							
(c) DUE TO Hypertension		<u>12 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u>		(County) <u>—</u>	(State) <u>—</u>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>3921 71st Street, N.W., Wash. 15, D.C.</u>							DATE SIGNED <u>Sept. 14, 1952</u>
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 71st Street, N.W., Wash. 15, D.C.</u>							
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Oakwood Cemetery</u>		22d. LOCATION (City, town, or county) <u>Troy</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chene Funeral Home, Inc.</u>		ADDRESS <u>5103 3rd Street, N.W., Wash. 15, D.C.</u>		24e. REG'D. BY REGISTRAR DATE <u>SEP 16 1958</u>		25. REGISTRAR'S SIGNATURE <u>John S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

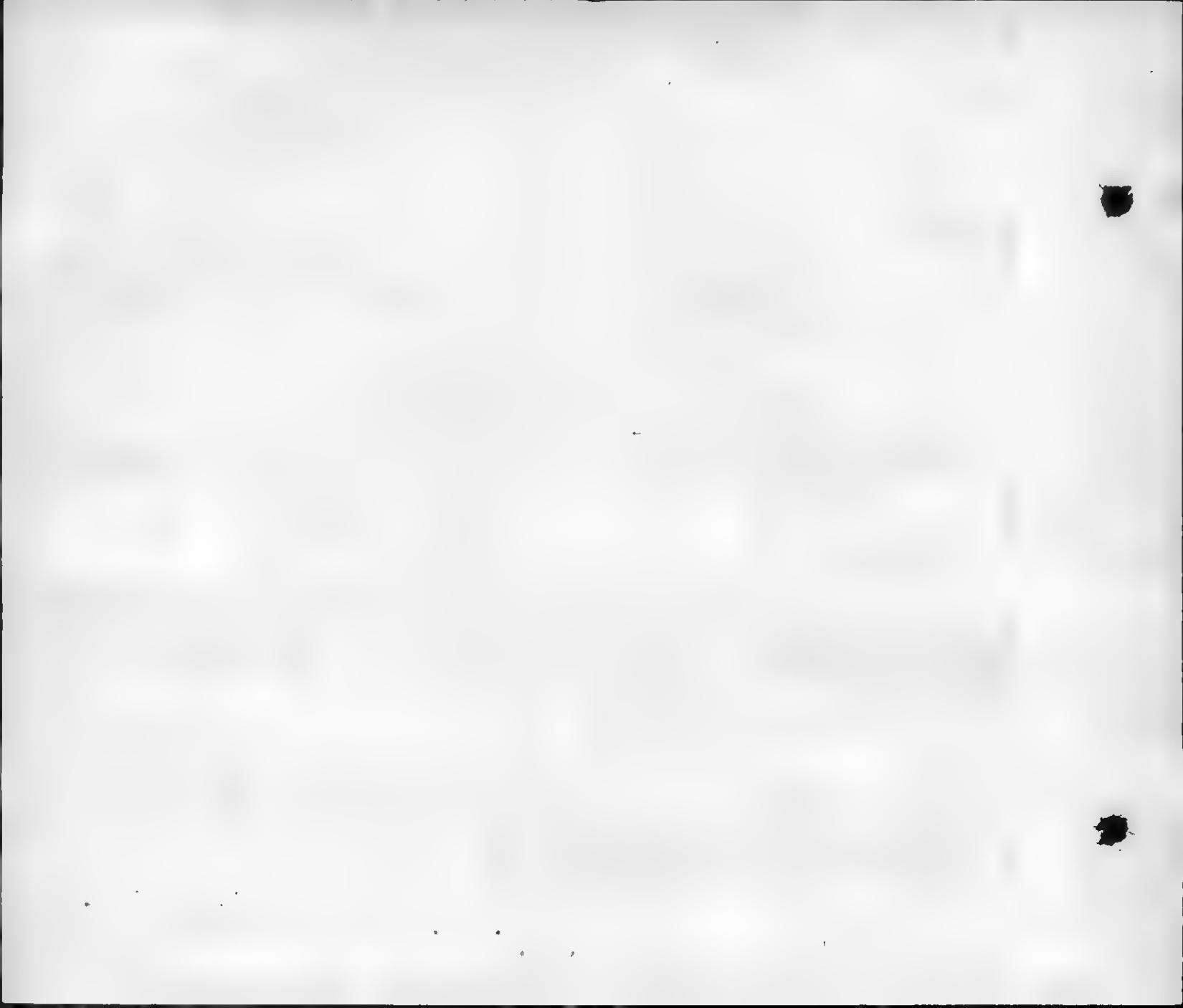


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film G234, 10/6/58, pg. 10293 **CERTIFICATE OF DEATH**

Reg. Dist. No. **10411**

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 2 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		d. STREET ADDRESS 1440 Univ. Blvd.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Overton Jeter Smith		First	Middle	Last	4. DATE OF DEATH 9 23 1958	Month	Day	Year		
5. SEX m		6. COLOR OR RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-88	9. AGE (In years from birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street oper.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? N Amer.				
13. FATHER'S NAME Kirby Smith		14. MOTHER'S MÄDEN NAME Hattie William		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 578-10-7585		17. INFORMANT Hospital records.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days.	
						RESPIRATORY FAILURE BRONCHIOGENIC CARCINOMA WITH METASTASES				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) GENERALIZED ARTERIO SCLEROSIS									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) 1352 Clemency Lane, Sykesville		(County)	(State)	
21. I certify that I attended the deceased from 7/11 1958 to 9/23 1958 , that I last saw the deceased alive on 9/22 1958 , and that death occurred at 4:05 PM , from the causes and on the date stated above.									ADDRESS (Street, city or town, Note) 1352 Clemency Lane, Sykesville	DATE SIGNED 10/25/58
ACTUAL SIGNATURE Donald Stein										
PHYSICIAN'S NAME (Type) Francis Gasch's Sons										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORIUM Antioch Church		22d. LOCATION (City, town, or county) Ex Guinea Mills		(State) Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS 4739 Balto. Av Hyattsville, Md.		44. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Moore				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10413

10294

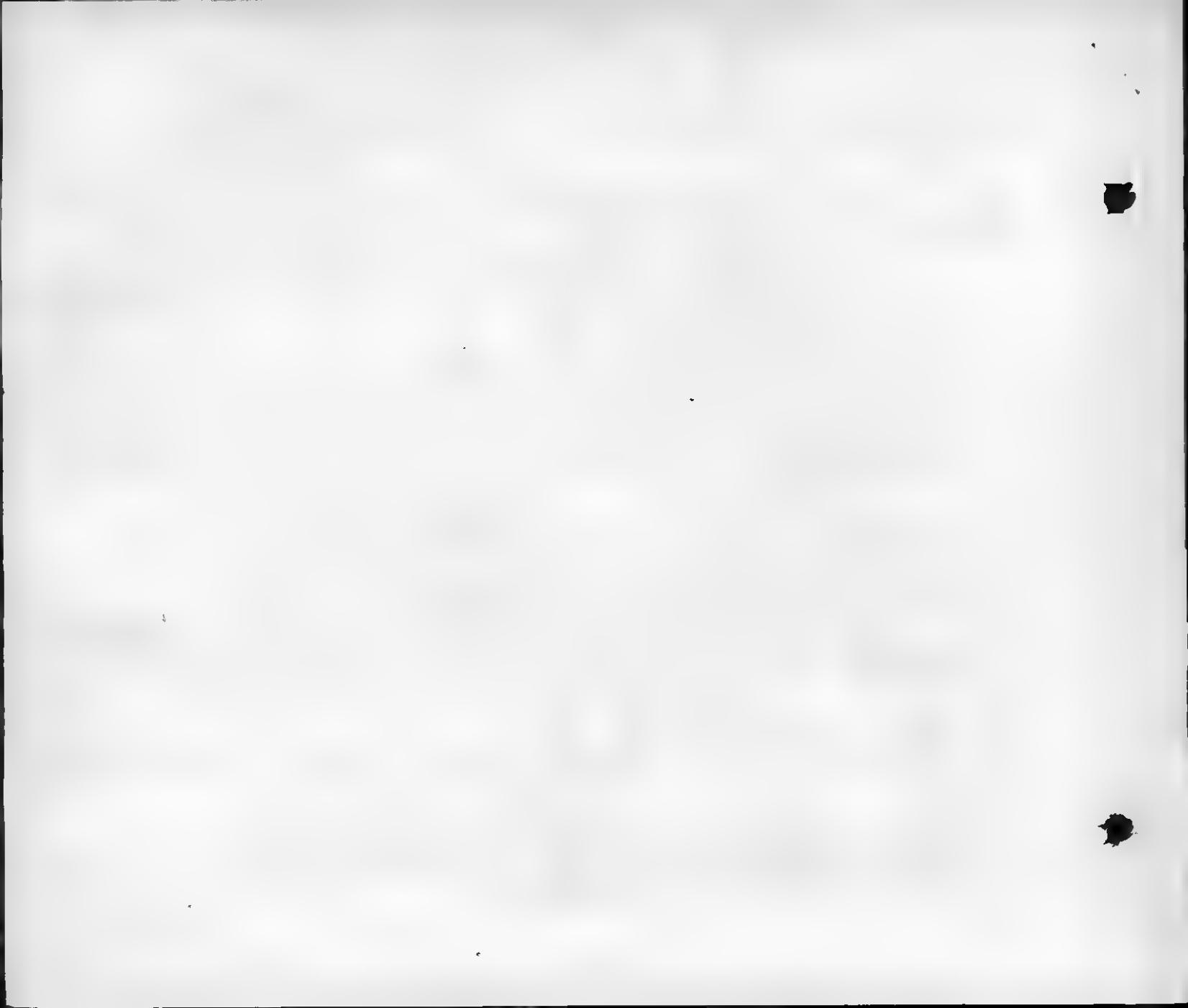
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pennsylvania</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			c. LENGTH OF STAY IN 1b <i>Washington Sanitarium & Hospital</i>			b. COUNTY <i>Philadelphia</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>			d. STREET ADDRESS <i>1527 Loudon St.</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Philadelphia</i>			
3. NAME OF DECEASED (Type or print)			First <i>ETTA</i>	Middle <i>Heller</i>	Last <i>STAMM</i>	4. DATE OF DEATH <i>9 - 22</i>	Month <i>9</i>	Day <i>- 22</i>	Year <i>1958</i>
5. SEX <i>Female</i>			6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i>	8. DATE OF BIRTH <i>11-29-80</i>	9. AGE (in years last birthday) <i>77 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>			11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>			12. CITIZEN OF WHAT COUNTRY? <i>America</i>
13. FATHER'S NAME <i>Louis Katz</i>			14. MOTHER'S MAIDEN NAME <i>Bertha Heller</i>			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>—</i>			17. INFORMANT <i>Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			<i>Posterior myocardial infarction</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>			
			<i>Generalized asthenclerosis</i>						<i>4 years.</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f (City or town) (County) (State)</i>			
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED <i>9-22-58</i>
ACTUAL SIGNATURE <i>Abraham W. Danish</i>			M.D.			22d LOCATION (City, town, or county) <i>Silver Spring, Md.</i>			(State) <i>MD</i>
PHYSICIAN'S NAME (Type) <i>ABRAHAM W. DANISH</i>			22e. NAME OF CEMETERY OR CREMATORIAL <i>Chelton Hills Crematory</i>			22f. DATE THEREOF <i>9/22/58</i>			
22g. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>			22h. DATE THEREOF <i>9/22/58</i>			24a. REC'D BY REGISTRAR DATE <i>SEP 23 '58</i>			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Juska,</i>			ADDRESS <i>Silver Spring, Md.</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's files. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



10427

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL
OR ~~envelope nearest town~~)
TOWN GermantownLENGTH OF STAY
(In this place)
3 Years

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Gaithersburg

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

The Marylander

Home

STREET
ADDRESS

N.F.D.

(If rural, give location)
I3. NAME OF
DECEASED
(First)
(Type or Print)

Katherine

C.

Sutliff

(Last)

DATE (Month)

(Day)

(Year)

OF DEATH Sept 5

1958

5. SEX
Female6. COLOR OR
RACE
White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)
Widowed8. DATE OF BIRTH
Dec. 23 18789. AGE last birthday
79 yrs.IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)
Domestic10b. KIND OF BUSINESS
OR INDUSTRY11. BIRTHPLACE (State or foreign country)
New York12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME

Michael E Carley

14. MOTHER'S MAIDEN NAME

Marie C. Fleming

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(No, or unk.) (If Yes, give war or dates of service)16. SOCIAL SECURITY NO.
None17. INFORMANT & ADDRESS
Vinoent Sutliff

As Same

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

IMMEDIATE CAUSE

(A) Acute Congestive HEART FAILURE

24 HRS.

ANTECEDENT CAUSE(S)

(B) DUE TO ArTERIO-SCLEROTIC HEART DISEASE

20 YRS.

DISEASES OR CONDITIONS, IF ANY,

(B) GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

DUE TO

(C) ESSENTIAL HYPERTENSION

25 YRS.

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

DISEASE OR CONDITION CAUSING DEATH.

4 YRS.

8 YRS.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from SEPT. 1952, to SEPT 5, 1958, that I last saw the deceased alive on SEPT 5, 1958, and that death occurred at 8:58 A.M., from the causes and on the date stated above.

SIGNATURE

Reverend S. Donnelly

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

Sept 8, 58

NAME OF CEMETERY OR CREMATORIUM

St. Marys Cemetery

LOCATION (City, town, or county)

(State)

Flushing

New York

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

DATE SEP 8 '58

Cathleen S. Kline

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

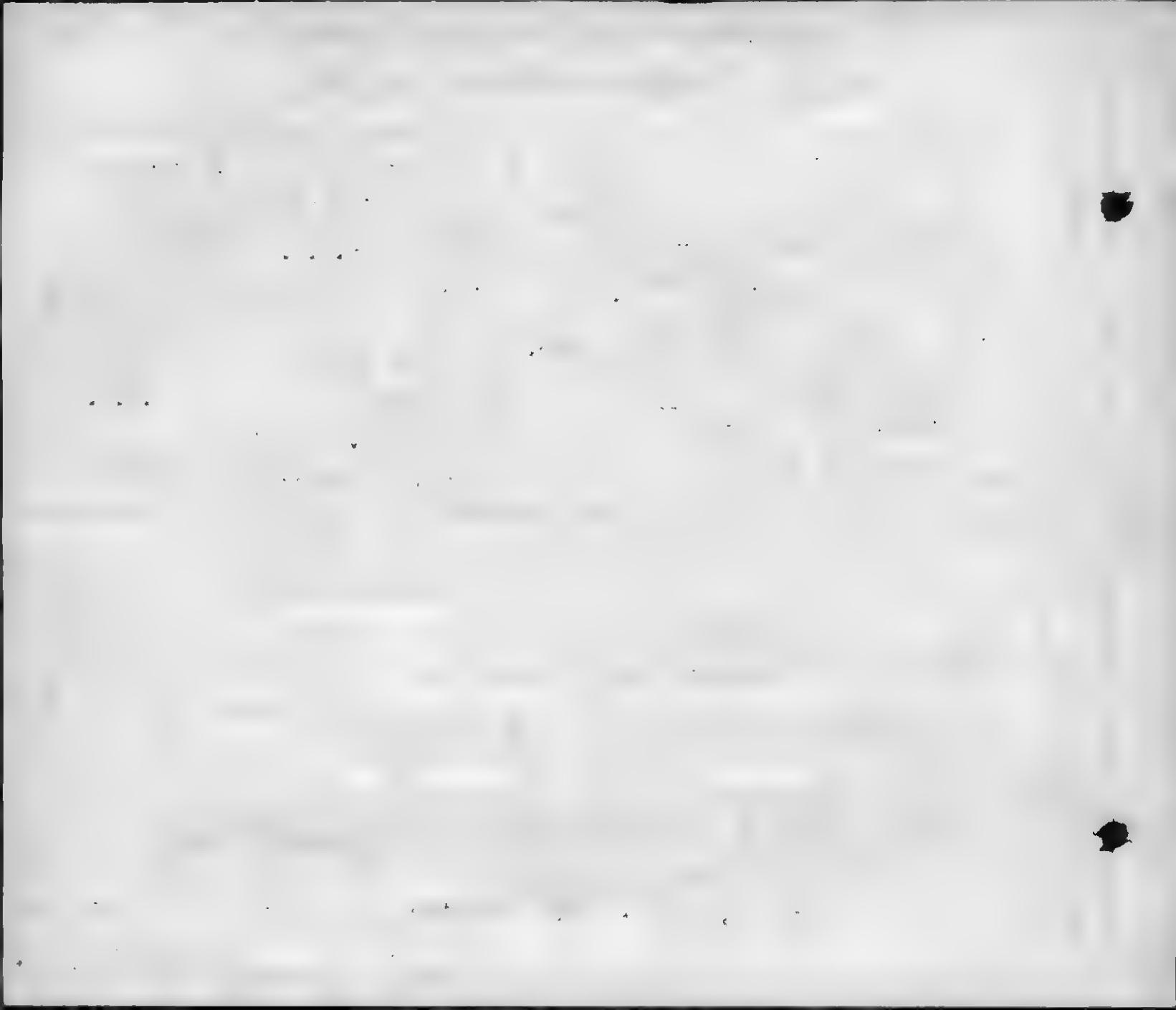
Boyle Barber

Laytonsville, Md.

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10428

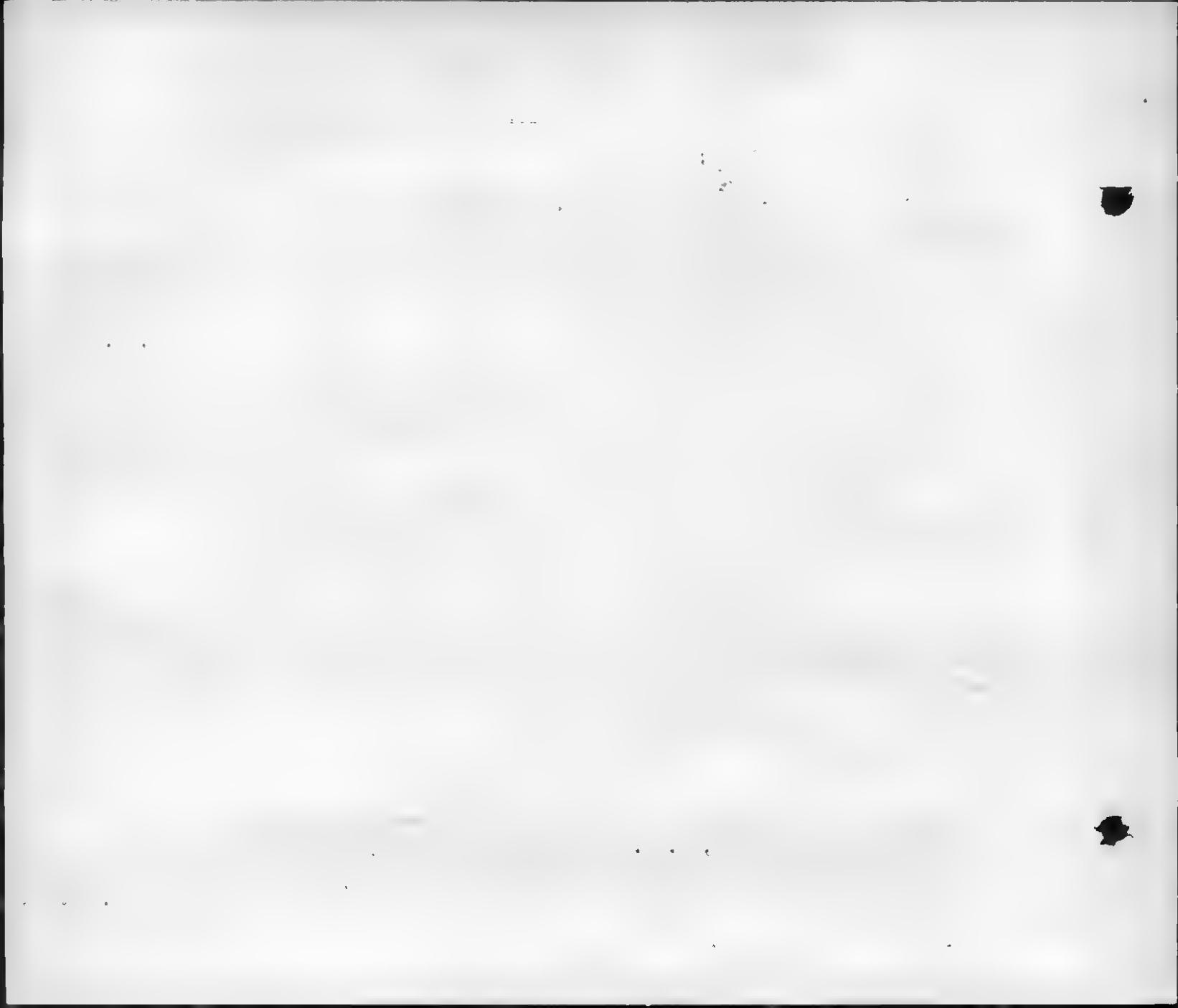
CERTIFICATE OF DEATH

10414

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician an^d may be retained by the hospital or attending physician an^d completely filled in the funeral home or mortuary. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 7647 Greenleaf Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Phillip	Last Sutphin	4. DATE OF DEATH September 14, 1958	Month September	Day 14	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Sutphin			14. MOTHER'S MAIDEN NAME Molly Sutphin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Staphlococcal Septicemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <i>Staphlococcal Bacteriopneumonia</i> DUE TO (c) <i>Acute Leukemia</i> INTERVAL BETWEEN ONSET AND DEATH 3-4 days " " Open 8 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) L. I. I.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 19, 1958, to September 14, 1958, that I last saw the deceased alive on September 14, 1958, and that death occurred at 3:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leonard Garren</i> , M.D.		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/1958		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cem.		22d. LOCATION (City, town, or county) Colmar Manor, Pr. Geo. Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W.Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR SEP 22 1958 DATE		24b. REGISTRAR'S SIGNATURE <i>W.W. Chambers</i>	



1

FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

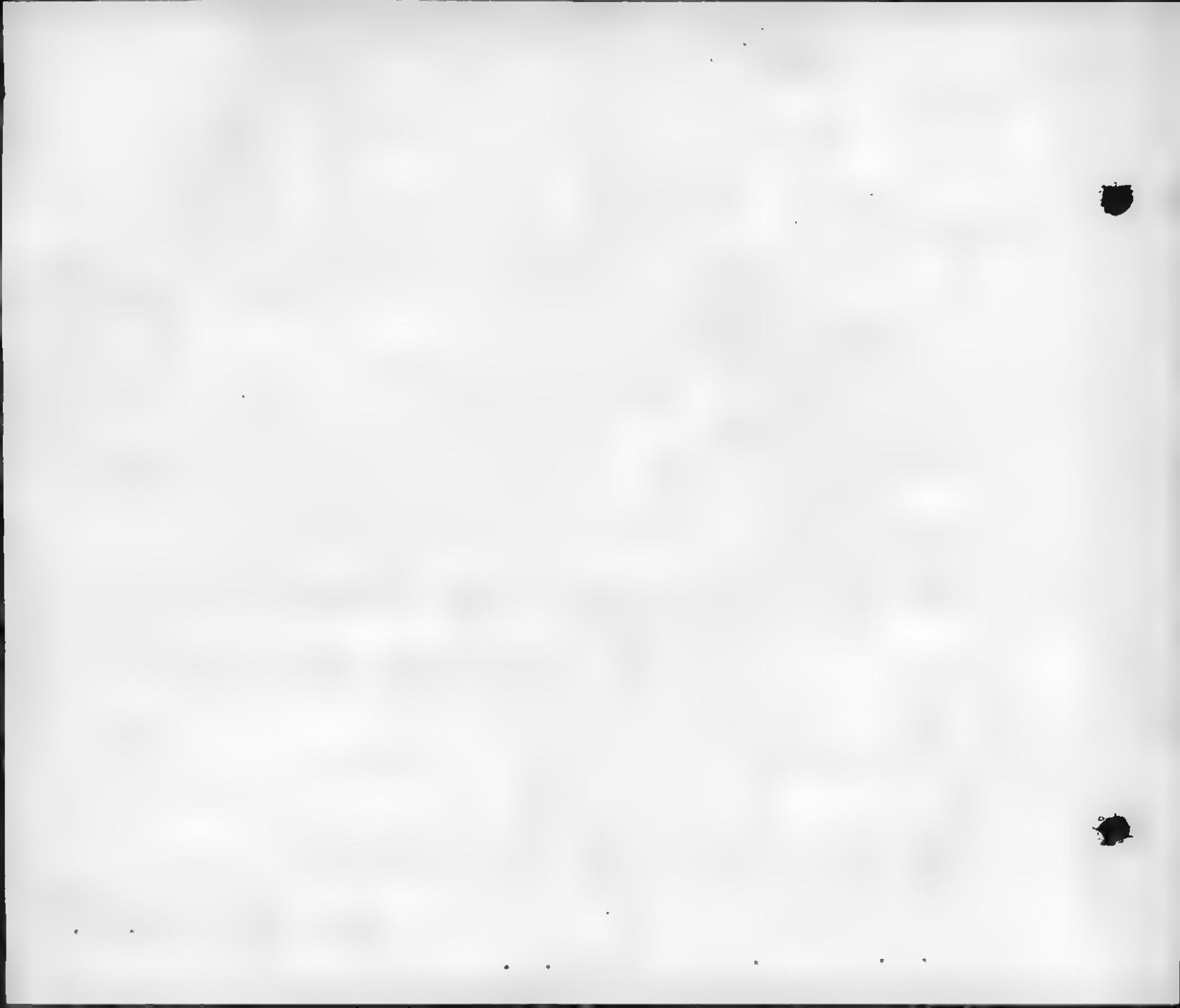
10415

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE				
Montgomery MARYLAND		Md b. COUNTY Monty				
b. CITY OR TOWN (If outside corporate limits, wr to RURAL and give nearest town)		c. LENGTH OF STAY IN lb Cabin John 2 yrs				
Cabin John		d. CITY OR TOWN (If outside corporate limits, wr to RURAL and give nearest town) Cabin John				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7802 Tomlinson Ave		e. STREET ADDRESS 7802 Tomlinson Ave				
3. NAME OF DECEASED (Type or print)		First	Middle			
Alonzo Morgan Thomas Jr.						
4. DATE OF DEATH		Month	Day			
Sept 1 1958						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min
Male white				7-5-1913	45 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Civil Engineer		D.C. GOVT.		D.C.		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Alonzo M. Thomas		Selma		Wendt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		
YES WW2				Selma Thomas (Mother) D.L. 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion				
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a. m. p. m.		Month Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED 9-1-58				
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type)		22b. DATE THEREOF 9/1/58				
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince Georges Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR SEP 3 '58				
VS. A15ME SM 2/57		24b. REC'D BY SIGNATURE Arthur S. Kraus				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, Film G-234 9/26/58.cac.

10416

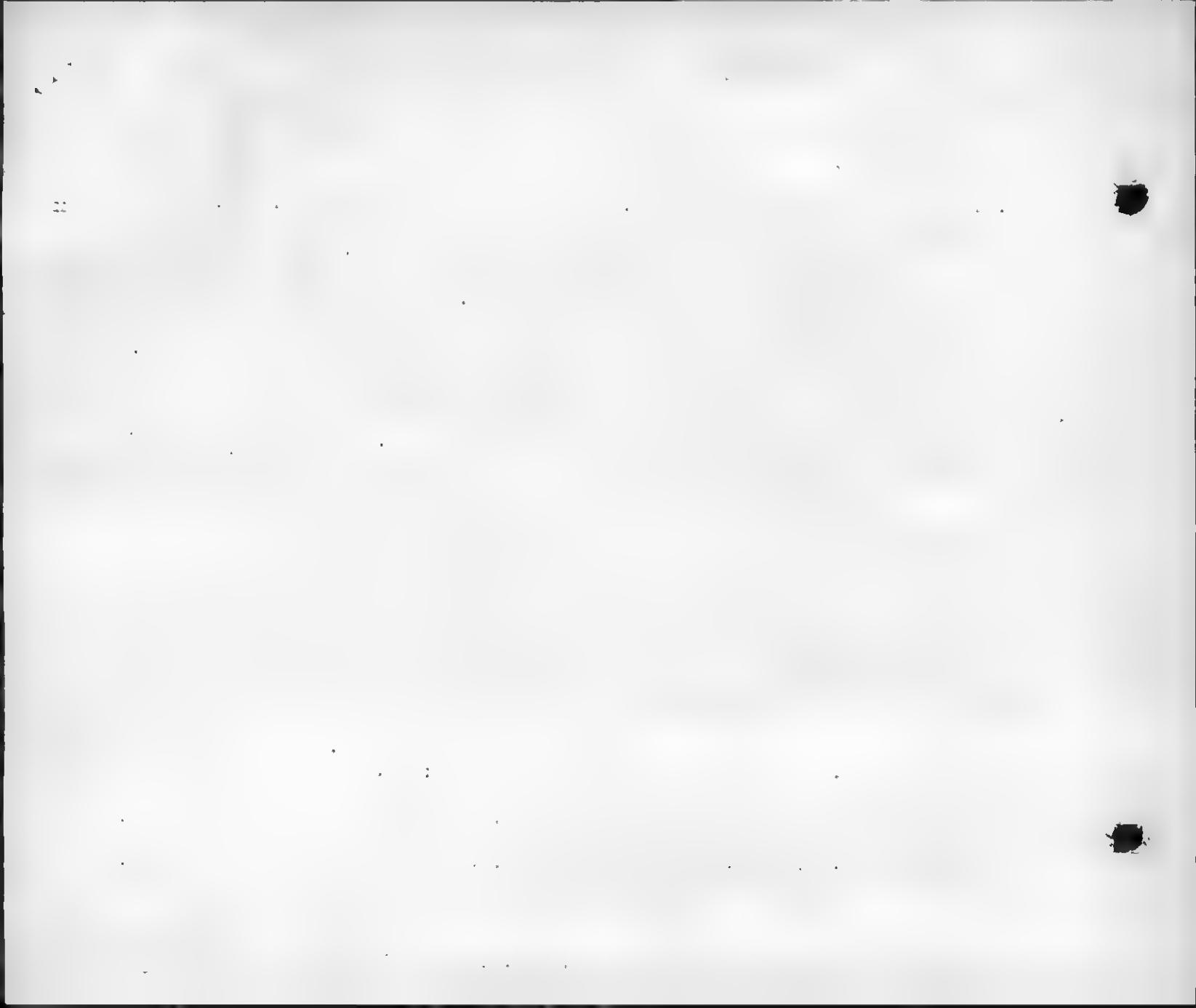
10430

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then revere carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 22 days		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE District of Columbia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1524 Potomac Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elise E1616		First E1616	Middle "S"	Last THOMPSON	4. DATE OF DEATH September 14 1958	Month September	Day 14	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Sept. 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Soren ANDERSEN		14. MOTHER'S MAIDEN NAME Ellen ANDERSEN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----- Unknown		17. INFORMANT (Husband) Axel K. THOMPSON (Same As #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, Left Breast with Metastases						INTERVAL BETWEEN ONSET AND DEATH Undetermined			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO									
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 23 August 1958 to 14 Sept. 1958 , that I last saw the deceased alive on 14 Sept. 1958 , and that death occurred at 11:00P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	DATE SIGNED 9-15-58
ACTUAL SIGNATURE <i>Burt C. Johnson</i>									
PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass Ave., N.W. Wash.D.C.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 19 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrall</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10417

10431

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>District of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Norbeck</i>	c. LENGTH OF STAY IN 1b <i>RURAL and nearest town</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	d. STREET ADDRESS <i>1604 Michigan Ave. N.E.</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Philomena's Rest Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Alice K. Towles</i>	First <i>Alice</i>	Middle <i>K.</i>	Last <i>Towles</i>
4. DATE OF DEATH <i>9 - 7 - 58</i>	Month <i>9</i>	Day <i>7</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/8/1886</i>
9. AGE (In years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk Ret. Interstate Commerce Comr. Govem.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S.</i>	
11. BIRTHPLACE (State or foreign country) <i>Elkins W. Va.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>William L. Kee</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Theris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Laurene E. Towles</i>	
17. INFORMANT <i>Address 1604 Mich Ave. Wash. D.C. NE</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gromi Cardiol'ascular hepatitis</i>	
442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>-&clerosis</i>		DUE TO (b) <i></i>	
		DUE TO (c) <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7 Sept 58</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8 June 58</i> , to <i>7 Sept 58</i> , that I last saw the deceased alive on <i>31 Aug 58</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert C. Haile</i> ADDRESS (Street, city or town, state) <i>35-N.Y. Ave. N.W. D.C.</i> DATE SIGNED <i>9/7/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/10/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mr. Oliver</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home</i>		24a. REC'D BY REGISTRAR ADDRESS <i>Mt. Rainier Md.</i> DATE <i>SEP 11 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10418

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
Montgomery				a. STATE	Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	Montgomery		
Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		9938 Mayfield Drive		d. STREET ADDRESS	9938 Mayfield Drive		
e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day
Bettye		JO	TREMMEL		Sept. 23, 1958	19	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 4, 1922	36 yrs	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Illinois		US	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Joseph E. Snyder		Ailley C. Sterrett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		None		Ernest E. Tremmel-husband-same as 2a			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Hemorrhage							
777X							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause last.							
(b) DUE TO							
(c)							
found dead on bedroom floor							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Reported to have been under psychiatric treatment							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		Self inflicted wound in left chest					
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> 9/23/1958 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Bethesda, Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE. <i>Frank J. Broschart</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart		9/23/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/58		22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven		22d. LOCATION (City, town, or county) Silver Spring, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		24a. REC'D. BY REGISTRAR SEP 25 1958					
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Mann</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 235 11-13-58 ams

10295

CERTIFICATE OF DEATH

Reg. Dist. No.

10419

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>MONTGOMERY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>		d. STREET ADDRESS <i>7107 Cedar Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7107 Cedar Avenue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Judith ANN</i>	Middle <i>RAY</i>	Last <i>VERE</i>	4. DATE OF DEATH <i>Sept. 18 1958</i>	Month	Day	Year
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5. SEX <i>F</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>June 25, 1958</i>	9. AGE (In years lost birthday) yrs <i>2 23</i>	IF UNDER 1 YEAR Months <i>2 23</i>	IF UNDER 24 HRS Days <i>2 23</i>	Hours <i>2 23</i>	Min. <i>2 23</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>JOHN W. VERE</i>	14. MOTHER'S MAIDEN NAME <i>GERTRUDE A. THOMPSON</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>123-45-6789</i>	17. INFORMANT <i>Mr. John W. Vere, 7107 Cedar Ave.</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>774X</i> DUE TO <i>Focal interstitial pneumonitis, early</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>Obesity</i>	
(b) <i>possible Sarcoidosis (pending blood test)</i>	
(c) <i>Capillary hemangioma of skin and liver</i>	

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>possible Sarcoidosis (pending blood test)</i>

20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. <i>Sept. 16, 1958</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>9927 Pershing Dr., Silver Spring, Md.</i>	20f. (City or town) <i>SILVER SPRING</i>	(County) <i>MARYLAND</i>	(State) <i>M.D.</i>
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21. I certify that I attended the deceased from <i>Sept. 16, 1958</i> , to <i>Sept. 16, 1958</i> , that I last saw the deceased alive on <i>Sept. 16, 1958</i> , and that death occurred at <i>7 A.M.</i> , from the causes and on the date stated above.
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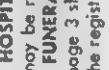
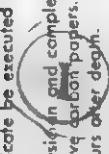
ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE <i>Winston E. Cochran</i>	PHYSICIAN'S NAME (Type) <i>Winston E. COCHRAN</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>	22b. DATE THEREOF <i>9/19/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN CEMETORY</i>	22d. LOCATION (City, town, or county) <i>PRINCE GEORGE COUNTY, MD.</i>
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24a. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>	ADDRESS <i>SILVER SPRING, MD.</i>	24b. REC'D BY REGISTRAR DATE SEP 22 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10420

10433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	c. LENGTH OF STAY IN 1b 8 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban	d. STREET ADDRESS 10519 Warfield St. 10519		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EARL	First A	Middle	4. DATE OF DEATH Month Sept Day 15 Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month 3 Day 5 Year 1914
9. AGE (In years lost birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY Plumbing Cont	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME WA. WAGNER	
14. MOTHER'S MAIDEN NAME LAVINIA DAYMUD		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. Yes-Unknown Mrs. William A Wagner-same as 2D		17. INFORMANT Mother	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1.0 DUE TO Hemorrhage From Esophageal Varices INTERVAL BETWEEN ONSET AND DEATH 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO PORTAL CIRRHOsis YPHNS (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SQUAMOUS CELL CARCINOMA PHARYNX WITH OSPOSUS METASTASES			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1950, to Sept 15, 1958, that I last saw the deceased alive on Sept 14, 1958, and that death occurred at 6:03 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE DeWitt E. Delawter	M.D.	DATE SIGNED 9/15/58	
PHYSICIAN'S NAME (Type) DeWitt E. Delawter		8025 ABERDEEN RD Bethesda, MD, 20814	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/17/58	22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) Prince Geo. Co. Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR DATE SEP 16 '58
			24b. REGISTRAR'S SIGNATURE C. Lee & Trahan

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10421

10434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5004 DelRay Avenue				d. STREET ADDRESS 5004 DelRay Avenue					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
BERTHA		M. A.		WAHL	September	13	19	58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 14, 1871	9. AGE (In years from birthday) 86 yrs.	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS Days 29	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home					
11. BIRTHPLACE (State or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME ? Kroeger				14. MOTHER'S MAIDEN NAME ? Filter					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO None		17. INFORMANT John A. Wah.-son-4826 McArthur Blvd. N.W.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) arteriosclerotic heart disease				Acute pulmonary edema congestive heart failure 3 mos. 5 yrs.				INTERVAL BETWEEN ONSET AND DEATH 20 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 14.1949, to 13 Sept. 1958, that I last saw the deceased alive on 13 Sept. 1958, and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE John M. Wyman M.D. 2659 Old Georgetown Rd. Beth 9/13/58									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/58		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey Bethesda, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 16 '58		24b. REGISTRAR'S SIGNATURE Cathleen S. Kranz	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

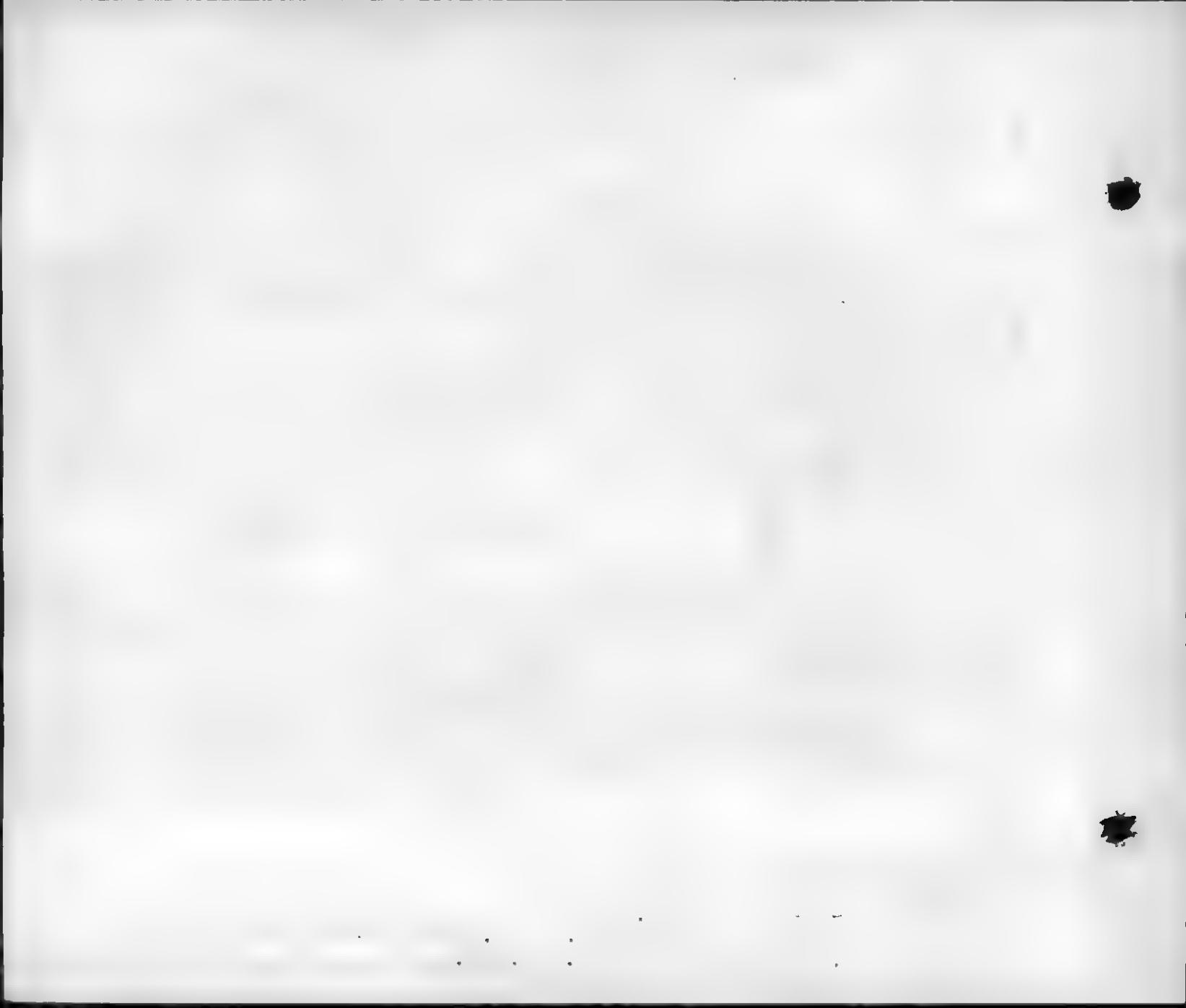
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10422
Item 1-2 and 4 10-2-58 et 10435 CERTIFICATE OF DEATH										
										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY MCNT GEMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MCNT GEMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XGaithersburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Hutton Street			d. STREET ADDRESS 105 Hutton St						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-74	9. AGE (In years last birthday) 34 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Ireland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Ryan			14. MOTHER'S MAIDEN NAME Mary Connell						Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. -			17. INFORMANT Monica Ward 503a 1st St. N.W. Washington D.C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO (b) Heart Failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Cerebral Vascular Accident Hypertension, Arteriosclerosis.										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o.p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 12, 1958, to 9/24, 1958, that I last saw the deceased alive on Sept 21, 1958, and that death occurred at 10:00 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Luciano P. Leal M.D. 108 N. Frederick Ave.										ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type) Luciano P. Leal Gaithersburg Md.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-24-58		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery			22d. LOCATION (City, town, or county) Melrose, Iowa (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS Wash. D. C.		24a. REC'D. BY REGISTRAR SEP 26 '58			24b. REGISTRAR'S SIGNATURE Arthur S. Krause			
RE Francis J. Collins 3821 14th. St. N.W.		DATE								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

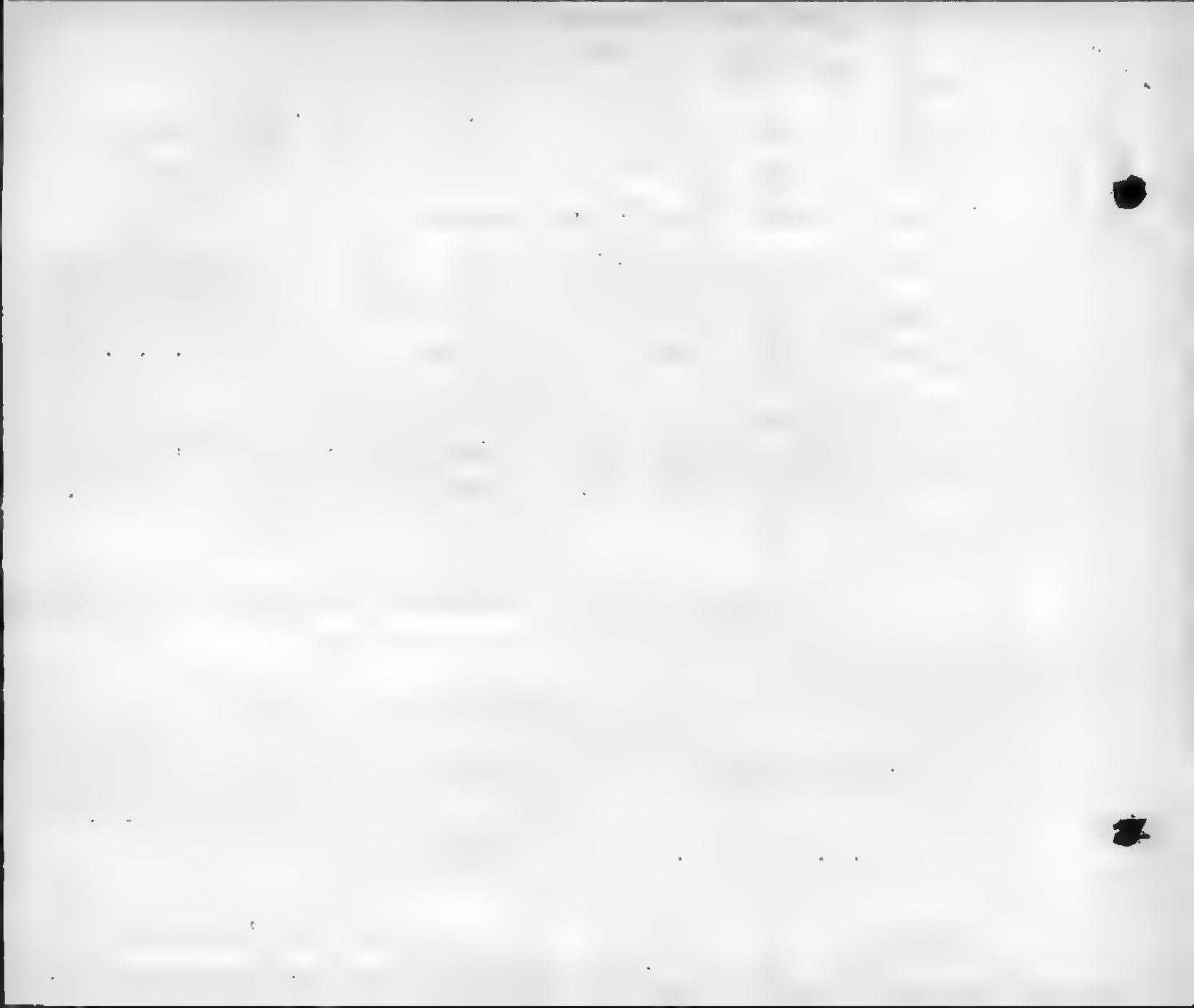
10423

10436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Virginia		b. COUNTY Loudon	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bluemont		d. STREET ADDRESS RD #1, Box 85	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Shamrock	Last Warner	4. DATE OF DEATH	Month September	Day 23	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1880		9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Masonry		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Warren				14. MOTHER'S MAIDEN NAME Katherine Jordan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of Prostrate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from September 2, 1958 , to September 23, 1958 , that I last saw the deceased alive on September 23, 1958 , and that death occurred at 6:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-23-58							
ACTUAL SIGNATURE <i>J. R. Rose (RJ)</i>	M.D.		The Clinical Center The National Institutes of Health Bethesda 14, Maryland				
PHYSICIAN'S NAME (Type) J. R. Rose, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/58	22c. NAME OF CEMETERY OR CREMATORIUM Negro Cemetery	22d. LOCATION (City, town, or county) (State) Middleburg, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Humphrey 7532 Wisconsin Ave Bethesda</i>	ADDRESS <i>In 200</i>	24a. REC'D BY REGISTRAR SEP 25 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

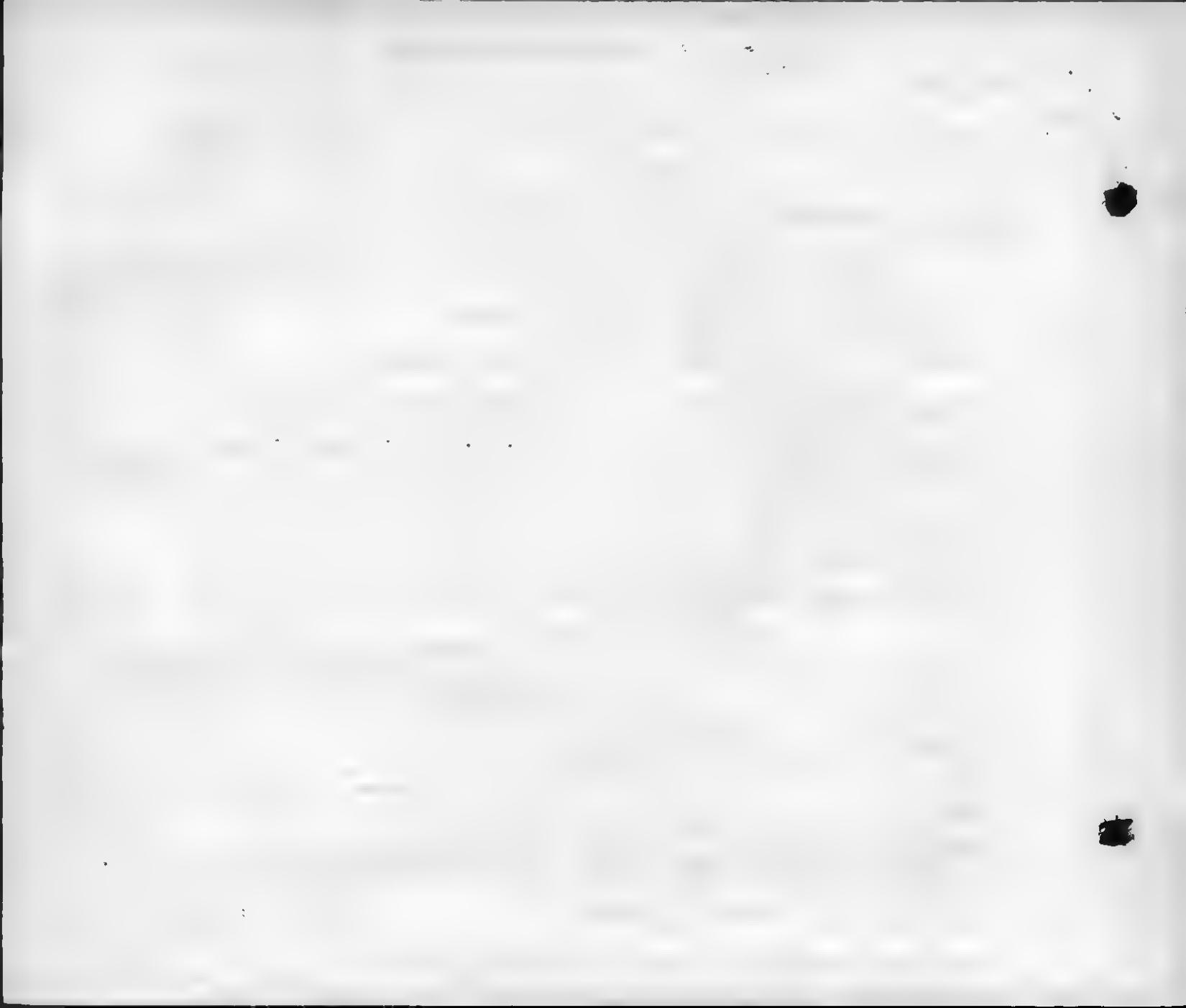
10437

CERTIFICATE OF DEATH

Reg. Dist. No.

10424

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 9811 Culver Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9811 Culver Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DOROTHY		First MAY	Middle WATT	4. DATE OF DEATH Sept 8 1958	Month Sept	Day 8	Year 1958
5. SEX FEMALE		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1914	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Safeway Store		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Nicholas Siegel		14. MOTHER'S MAIDEN NAME Margaret Watson		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 165-20-7834		17. INFORMANT Wm. N. Watt-Husband-item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X		DUE TO		Rheumatic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH ? YEARS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 1957 to Sept 8 1958 , that I last saw the deceased alive on August 7, 1958 , and that death occurred at 9:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 8025 ABERDEEN Rd. Bethesda Md 20814 DATE SIGNED 9/8/58							
ACTUAL SIGNATURE DeWitt E. DeLawter		M.D. 8025 ABERDEEN Rd. Bethesda Md 20814					
PHYSICIAN'S NAME (Type) DEWITT E. DELAWTER		8025 Aberdeen Rd. Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



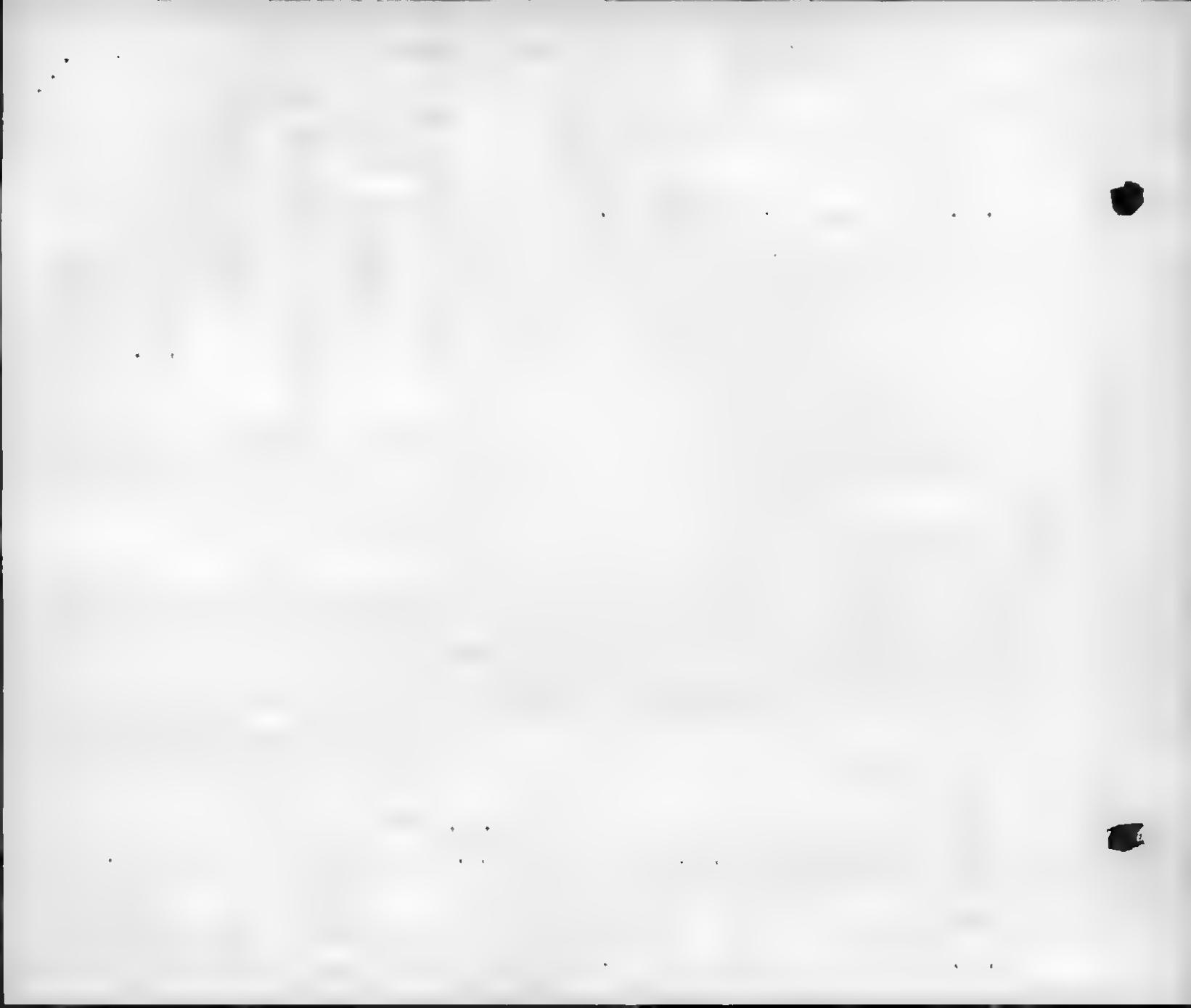
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10438

CERTIFICATE OF DEATH

10425
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Germantown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS Schniders Trailor Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Anthony	Middle Faron	Last WHITE	4. DATE OF DEATH September 2 1958	Month September	Day 17	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 2 September 1958	9. AGE (In years last birthday) yrs 15	IF UNDER 1 YEAR Months 15	IF UNDER 24 HRS Hours 15	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lee Olin WHITE				14. MOTHER'S MAIDEN NAME Ida Ann DUVALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Lee Olin WHITE (Same as #2)	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I - DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH 18 days 15 days			
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 September 1958 to 17 September 1958 , that I last saw the deceased alive on 17 September 1958 , and that death occurred at 1:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David Harris				ADDRESS (Street, city or town, state) U. S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-17-58			
PHYSICIAN'S NAME (Type) David Harris, LT, MC, USN		U. S. Naval Hospital, Bethesda, Md.					
22a. BURIAL Cremation, <input type="checkbox"/> Burial <input checked="" type="checkbox"/> (Specify) Cremation	22b. DATE THEREOF 9-19-58	22c. NAME OF CEMETERY OR CREMATORIAL Forest Oak Cemetery		22d. LOCATION (City, town, or county) Gaithersburg		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey, Funeral Home	ADDRESS R. A. Pumphrey, 7757 Wisconsin Ave. Bethesda, Md.	24a. REC'D. BY REGISTRAR SEP 19 1958		24b. REGISTRAR'S SIGNATURE John S. Marie			



FOR STATE
HEALTH DEPT.

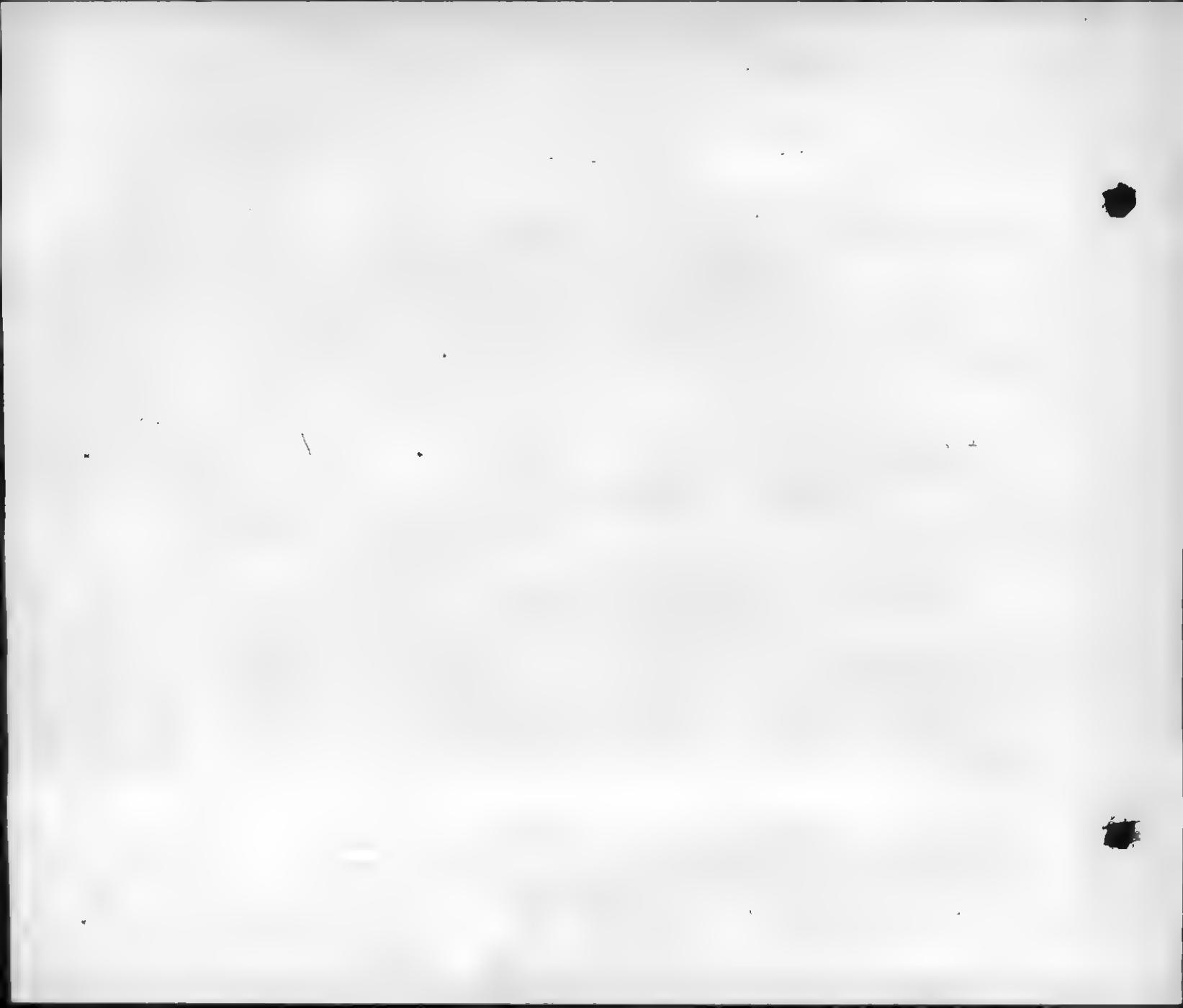
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10426

Reg. Dist. No.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same office, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 16 10 Year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6816 Brookville Rd.		e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) x Chevy Chase	
3. NAME OF DECEASED (Type or print) Harry Franklin White		d. STREET ADDRESS 6816 Brookville Rd.	
3. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 5/24/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Gov. employee	
10c. BIRTHPLACE (State or foreign country) Pa.		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin White		14. MOTHER'S MAIDEN NAME Martha Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Spanish		16. SOCIAL SECURITY NO None	
17. INFORMANT Bernard H. White, / Radnor, Penn.		Address 582 Cricket INTERVAL BETWEEN ONSET AND DEATH sudden	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), starting the underlying cause first. (b) _____ DUE TO (c)		Coronary occlusion	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/15/58
EXAMINER'S NAME (Type) Frank J. Broschart			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 17	22c. NAME OF CEMETERY OR CREMATORIUM Laytonsville	22d. LOCATION (City, town, or county) Laytonsville (Md.)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kayle Barber</i>	ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR DATE SEP 18 '58	24b. REG STAR'S SIGNATURE <i>Arthur S. Trahan</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, File # 10/10/58.cac.

10427

10296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Maryland</i>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>District of Columbia</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>16 hours</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>1401 Sheridan St. N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Margaret</i>	Middle <i>Rachel</i>	Last <i>White</i>
4. DATE OF DEATH	Month <i>Sept</i>	Day <i>10</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12 - 30 - 78</i>
9. AGE (In years last birthday) <i>77 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	14. MOTHER'S MAIDEN NAME <i>Mary F. Fluery</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>110-00-0000</i>	17. INFORMANT <i>Hospital record</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO <i>Pneumonia, Left + Right lung</i> 28 hours <i>Arteriosclerotic Cardiovascular Disease</i> 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anemia, Pernicious type. Diabetes Mellitus</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>49</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>49</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct</i> , 19 <i>58</i> , to <i>Sept 10</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 10</i> , 19 <i>58</i> , and that death occurred at <i>8:05 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>George B. Patrick Jr. M.D. 8700 Colesville Rd. 9-10-58</i>			
ACTUAL SIGNATURE <i>George B. Patrick Jr.</i>		DATE SIGNED <i>9-10-58</i>	
PHYSICIAN'S NAME (Type) <i>George B. Patrick, Jr. MD</i>			
22a. BURIAL, CREMATION X (Specify) <i>9-13-1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Congressional Cem.</i>	
22b. LOCATION (City, town, or county) (State)		22d. REC'D BY REGISTRAR DATE <i>Washington, D.C.</i> <i>SEP 15 '58</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kline</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10440

CERTIFICATE OF DEATH

Reg. Dist. No.

10428

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		Montgomery	
Bethesda		15 mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Suburbans		9807 RIVER RD					

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Frederick				Whitmore	9	26	1958	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
Male	W.		April 17 1880	78	Months Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Express Del. man	Express Co	D.C.	U.S.A.

13. FATHER'S NAME	Joseph Whitmore	14. MOTHER'S MAIDEN NAME	Mary Carr
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	No	16. SOCIAL SECURITY NO.	Address 211 E. Bradford
		17. INFORMANT	Niece Mrs Ruth Beach Alexandria Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		2 days
151X Peritonitis		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) Perforation, Metastatic carcinoma to Colon		2 days
(c) Carcinoma of Stomach.		Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19		

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE	M.D.	14 Nov. 1958	15-9-26-33
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PHYSICIAN'S NAME (Type)	Baltimore 14 Nov. 1958		
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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)
	Sept 29 1958	Bethesda Rock Creek	Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Zurley Funeral Home	510 - e st NW	SEP 30 '58	Washington & Thomas

No 268		Montgomery T. G. Washington D.C.	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10429

10441 CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 hours		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		e. STREET ADDRESS 2915 Woodstock Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Newborn Infant	Middle Girl	Last Williams	4. DATE OF DEATH Sept. 11, 1958	Month Sept.	Day 11	Year 1958	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1958	9. AGE (In years last birthday) 2 yrs.	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS. Days 2	Hours 2	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Elmer M. Williams		14. MOTHER'S MAIDEN NAME Mary Elizabeth Maddox							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Elmer M. Williams		Address 2915 Woodstock Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (p), stating the underlying cause last. (b) DUE TO (c) <i>circumstances Anoxia</i>						INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above								ADDRESS (Street, city or town, state) DATE SIGNED 9/12/58	
ACTUAL SIGNATURE <i>William J. Evans</i>		PHYSICIAN'S NAME (Type) WILLIAM J. EVANS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/13/58		22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond J. Fisika</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE <i>Clinton E. Howell</i>			



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10430

10442

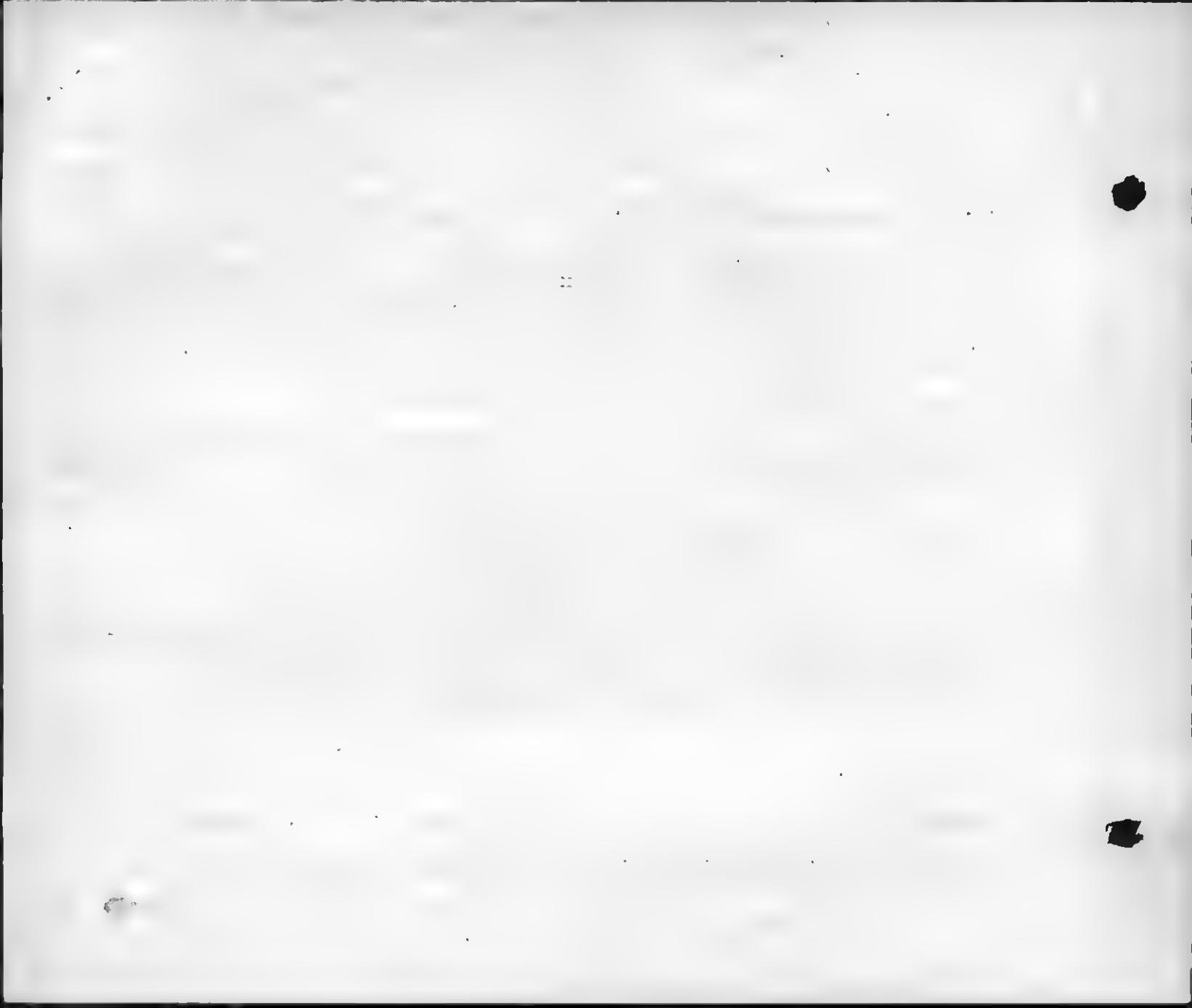
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Logue
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. STREET ADDRESS 6622 Willston Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Jeffrey	4. DATE OF DEATH WINSTEAD Month September Day 7 Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Sept. 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Finley Gilbert WINSTEAD		14. MOTHER'S MAIDEN NAME Joan Marie KLEIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT (Father) Finley G. Winstead (Same As #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). meningitis INTERVAL BETWEEN ONSET AND DEATH 751X 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) meningo-myelitis b " DUE TO (c) Spina bifida b " DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. Month p. m. Day 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Sept. 1958 , to 7 Sept. 1958 , that I last saw the deceased alive on 7 Sept. 1958 , and that death occurred at 4:10A.M. from the causes and on the date stated above.			
ACTUAL Howard A. Pearson		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-8-58	
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-11-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) Arlington, Virginia (State)
23. FUNERAL DIRECTOR'S SIGNATURE Marc A. Koenig		ADDRESS Arlington, Va. Arlington Funeral Home 3901 N.Fairfax Dr.	24a. REC'D BY REGISTRAR SEP 9 '58
		24b. REGISTRAR'S SIGNATURE C. L. Koenig	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

LENGTH OF STAY IN 1b

30 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

3. NAME OF

(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

9

Day

24

Year

1958

5. SEX

Male

6. COLOR OR RACE

W.

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

8-26-'44

9. AGE (In years
from birthday)

14

yr(s)

IF UNDER 1 YEAR

Months

1

Days

0

Hours

0

Min.

10. KIND OF BUSINESS OR INDUSTRY

Student

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Townley R. Wolfe

III

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Father

Townley R. Wolfe

III

Address

31 hours

INTERVAL BETWEEN
ONSET AND DEATH

31 hours

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MULTIPLE INTRACEREBRAL HEMORRHAGES

DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

DUE TO

(b)

MULTIPLE CEREBRAL CONTUSIONS AND LACERATIONS

DUE TO

(c)

31 hours

19. WAS AUTOPSY
PERFORMED?

YES

NO

20a. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

9/23 1958

9/24 1958

9/24 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10432 CERTIFICATE OF DEATH

Reg. Dist. No.

10432

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6809 Delaware St.		d. STREET ADDRESS 6809 Delaware Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) BARBARA		First Middle Lost		4. DATE OF DEATH Sept. 1 1958		Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/70	9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR 5 months	11. IF UNDER 24 HRS. 12 days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Daniel Artes		14. MOTHER'S MAIDEN NAME Sophia Keremlin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Karl Plitt-Item # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Acute Myocardial decomp		INTERVAL BETWEEN ONSET AND DEATH 3 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO Chronic myocardial decomp.		6 months				
(c)		Arteriosclerosis, general, severe		4 yrs +				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Bronchial Asthma, chronic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____	(County) _____	(State) _____
21. I certify that I attended the deceased from _____ March _____, 1958, to Sept 1, 1958, that I last saw the deceased alive on Aug 15, 1958, and that death occurred at 8:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Inganat St.		ADDRESS (Street, city or town, Note)		DATE SIGNED 9-1-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill		22d. LOCATION (City, town, or county) Washington, D.C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR SEP 2 58		24b. REGISTRAR'S SIGNATURE Arthur L. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17. JUNE 2014 • VOL 101 • NO 24 • 1723–1734 • www.jbc.org

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10445

CERTIFICATE OF DEATH

10433

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>36 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. STREET ADDRESS <i>14710-Essen Ave,</i>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>William J. Young</i>		First <i>W</i>	Middle <i>J.</i>		
4. DATE OF DEATH <i>Sept. 6 1958</i>	Month <i>Sept.</i>	Day <i>6</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/15/83</i>		
9. AGE (In years lost birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Father Attorney</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>	11. BIRTHPLACE (State or foreign country) <i>Salisbury, Mass.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Thomas J. Young</i>	14. MOTHER'S MAIDEN NAME <i>Martha Monroe</i>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>218-34-6325</i>	17. INFORMANT <i>Anna Young - Above</i>	INTERVAL BETWEEN ONSET AND DEATH <i>37 days</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <i>Arteriosclerosis, general, severe</i>		(b) DUE TO <i>Right Hemiplegia, severe, with aphasia</i>			
(c)		5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Left hemiplegia, severe</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE-OF-DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>-----</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-----</i>			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-----</i>	20f. (City or town) <i>-----</i>	(County) <i>-----</i>	(State) <i>-----</i>
21. I certify that I attended the deceased from <i>Sept. 5, 1958</i> , to <i>Sept. 6, 1958</i> , that I last saw the deceased alive on <i>Sept. 5, 1958</i> , and that death occurred at <i>7:20 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Stewart Clapp</i> M.D. <i>3921 Ingomar St NW 9-6-58</i> PHYSICIAN'S NAME (Type) <i>Stewart Clapp Wash 15 D.C.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/9/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>	22d. LOCATION (City, town, or county) <i>Rockville, Maryland</i>	(State) <i>-----</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey Bethesda, Maryland</i>		ADDRESS <i>-----</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 9 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

对了，你想起的那位朋友就是你的前妻，她现在怎么样了？